DOCUMENT RESUME

ED 190 867 CE 026 453

TITLE	Health Professions Educational Assistance and Nurse Training Act of 1980. Hearings before the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce, House of Representatives, Ninety-sixth Congress, Second Session on H.R. 6802 and 6800, March 20, 21, 24, 25, and 26, 1980. Serial No. 96-148.
INSTITUTION	Congress of the U. S., Washington, D. C. House Committee on Interstate and Foreign Commerce.
PUB DATE	Mar 80
NOTE	1,031p.; Not available in paper copy due to small print.
EDRS PRICE	MF07 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	Federal Aid; *Federal Legislation; *Federal Programs; Health Occupations; *Health Personnel; *Health Services; Hearings; Medical Education; National Programs
IDENTIFIERS	Congress 96th; *Public Health Service Act

ABSTRACT

Proceedings are presented of hearings before the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce concerning a bill to amend the public health service act to revise and extend the programs for the national health service corps and to revise and extend the programs of assistance under titles 7 and 8 for the education of health professions personnel. Among the organizations represented in testimony before the subcommittee were the American Association of Colleges of Nursing, American Dental Association, American Medical Association, American Nurses' Association, American Society of Allied Health Professions, American Federation of Teachers, and the National League for Nursing. (LRA)

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ED190867

HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE AND NURSE TRAINING ACT OF 1980

HEARINGS

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON
INTERSTATE AND FOREIGN COMMERCE
HOUSE OF REPRESENTATIVES

NINETY-SIXTH CONGRESS
SECOND SESSION

ON

H.R. 6802

A BILL TO AMEND THE PUBLIC HEALTH SERVICE ACT TO REVISE AND EXTEND THE PROGRAMS FOR THE NATIONAL HEALTH SERVICE CORPS AND TO REVISE AND EXTEND THE PROGRAMS OF ASSISTANCE UNDER TITLES VII AND VIII OF SUCH ACT FOR THE EDUCATION OF HEALTH PROFESSIONS PERSONNEL, AND FOR OTHER PURPOSES

H.R. 6800

A BILL TO AMEND PROVISIONS OF LAW CONCERNED WITH HEALTH PROFESSIONS EDUCATION

MARCH 20, 21, 24, 25, AND 26, 1980

Serial No. 96–148

Printed for the use of the
Committee on Interstate and Foreign Commerce

CE 026 453

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ACKNOWLEDGMENT

I gratefully acknowledge the contribution of Martin F. Kagnoff, M.D., a consultant on my personal staff who worked on this hearing with subcommittee professional staff members Brian Biles, M.D., Craig N. Oren, and Katherine C. Meyers. I am particularly proud of this work done by the Subcommittee on Health and the Environment, the authorizing subcommittee for the National Institutes of Health, the pre-eminent research center, not only for the United States, but for the world.

HENRY A. WAXMAN,
Chairman, Subcommittee on
Health and the Environment.

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American Association of Colleges of Nursing, Ruby Wilson, R.N., Ed. D.
American Association of Colleges of Osteopathic Medicine, Philip Pumerantz, member, board of governors; American Osteopathic Association; American Osteopathic Hospital Association.
American Association of Colleges of Pharmacy:
  Hill, Wendall T., Jr., Pharm. D.
  Schlegel, John, assistant executive director.
American Association of Colleges of Podiatric Medicine, Charles W. Gibley, Jr., Ph. D.
American College of Nurse-Midwives, Sally Austin Tom.
American College of Preventive Medicine, Kent W. Peterson, M.D., executive vice president.
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American Hospital Association:
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  McMahon, John Alexander, president.
American Medical Association:
  Blehart, Bruce, department of legislation.
  Ruhe, C. H. William, senior vice president.
American Nurses' Association, Loretta C. Ford, Ed. D., R.N., F.A.A.N.
American Osteopathic Association; American Osteopathic Hospital Association; American Association of Colleges of Osteopathic Medicine, Philip Pumerantz, member, board of governors.

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American Student Dental Association, Ralph Jay Van Brocklin, president and board chairman.

Association of American Medical Colleges:
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- Stemmler, Edward J., M.D.

Association of American Universities, Joint Committee on Health Policy:
- Bartlett, Thomas, Ph. D., president.
- Clodius, Robert, Ph. D.
- Pelatson, Jack W.

Association of American Veterinary Medical Colleges, Edward C. Melby, D.V.M., chairman, council of deans.

Association of Schools and Colleges of Optometry, Lee W. Smith, MPH, executive director.

Association of Schools of Public Health, Michael K. Gemmell, executive director.

Association of University Programs in Health Administration, Gary L. Filerman, Ph. D., president.

California Statewide Area Health Education Center Program, Malcolm S. M. Watts, M.D., project director.

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- Hines, Ralph H., Ph. D.

Educational Commission for Foreign Medical Graduates:
- Casterline, Ray L., M.D., executive director.
- Selfron, Maureen, managing director.

Federation of Nurses and Health Professions, American Federation of Teachers, American Federation of Labor and Congress of Industrial Organizations, Louise W. Esiason, R.N., M.A.

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- Hatch, Thomas, Acting Director, Bureau of Health Professions, Health Resources Administration, Public Health Service.
- Martin, Edward D., M.D., Director, Bureau of Community Health Services, Health Services Administration, Public Health Service.
- Richmond, Julius B., M.D., Assistant Secretary for Health and Surgeon General, Public Health Service.
- Tarlov, Alvin R., M.D., Chairman, Graduate Medical Education National Advisory Committee (HEW).

International Communication Agency, Joseph A. Blundon, assistant general counsel.

National League for Nursing, Carolyne K. Davis, R.N., Ph. D.

National Rural Center:
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- Madison, Donald, M.D.

National Student Nurses' Association, Inc., Russell Perry, member, board of directors.

New Jersey area Health Education Center program, Merwyn A. Landay, D.D.S., M.B.A., director.

North Carolina Area Health Education Center Program, Eugene S. Mayer, M.D., M.P.H., director.

Office of Technology Assessment, U.S. Congress:
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- Doty, Pamela, Congressional Fellow (OTA study).
- Miike, Lawrence, Project Director (OTA study).

Society of Teachers of Family Medicine, Terry Kane, M.D., president.

Urban Institute, The, Jack Hadley, Ph. D., senior research associate.

HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE AND NURSE TRAINING ACT OF 1980

THURSDAY, MARCH 20, 1980

House of Representatives,
Subcommittee on Health and the Environment,
Committee on Interstate and Foreign Commerce,
Washington, D. C.

The subcommittee met, pursuant to notice, at 2 p.m., in room 2123, Rayburn House Office Building, Hon. Henry A. Waxman, chairman, presiding.

Mr. **Waxman**. The subcommittee will come to order.

This afternoon the subcommittee begins its hearings on the extension of the authorization for the health professions education assistance and nurse training programs. These programs are important because they help assure that the Nation will be supplied with highly skilled health professionals over a period running well into the next century.

These hearings and the subsequent deliberations of the subcommittee, are more significant this year than ever. Because of the current efforts to balance the Federal budget we must be certain that programs are well designed and carefully managed. This is not the time for inefficiency or waste.

But beyond vigilance against waste, I believe we must be careful to insure that the current concern with the budget does not lead us to renege on our commitment to improve the health care available to the American people. The health care which can be provided by U.S. physicians is the finest in the world, yet for many of our people this care is out of reach.

This subcommittee has, over the years, fashioned a variety of programs, among them those assisting our health training programs to guarantee that excellent health care is delivered to all of our people.

In particular, health manpower programs can improve the geographic distribution of health professionals. Programs such as the National Health Services Corps and the Area Health Education Centers can do much to increase the number of providers in rural and inner-city areas. Manpower programs may also contribute to the increased availability of primary care, the kind of care most people need most often.

Conditions for institutional support, special project grants and changes in the health care payment system can all contribute to an increase in the number of new physicians entering primary care specialties.

Federal support can also assist our health training institutions and students. Institutional grants of both a general and special project nature contribute to the future fiscal viability of our health training institutions. Similarly in an inflationary time with tuition increases announced each year, funds from scholarships, loans and loan guarantees are critical to students. Of special importance are programs of training of students from disadvantaged backgrounds.

Without objection the text of H.R. 6802 and H.R. 6800 and any agency reports thereon will be placed at this point in the record.

[Testimony resumes on p. 104.]

[The text of H.R. 6802 and H.R. 6800 and agency report on H.R. 6800 follow:]

96TH CONGRESS
2D SESSION

H. R. 6802

To amend the Public Health Service Act to revise and extend the programs for the National Health Service Corps and to revise and extend the programs of assistance under titles VII and VIII of such Act for the education of health professions personnel, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 12, 1980

Mr. **WAXMAN** (for himself, Mr. **PREYER**, Mr. **MAGUIRE**, Mr. **LELAND**, and Mr. **CARTER**) introduced the following bill; which was referred jointly to the Committees on Interstate and Foreign Commerce and Ways and Means

---

A BILL

To amend the Public Health Service Act to revise and extend the programs for the National Health Service Corps and to revise and extend the programs of assistance under titles VII and VIII of such Act for the education of health professions personnel, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE; REFERENCE TO ACT; AND TABLE OF CONTENTS

SECTION 1. (a) This Act may be cited as the "Health Professions Educational Assistance and Nurse Training Amendments of 1980".

(b) Whenever in this Act (other than in titles V and VI) an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.

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Sec. 601. Alien graduates of foreign medical schools.

TITLE I—NATIONAL HEALTH SERVICE CORPS PROGRAMS

REVISION AND EXTENSION OF NATIONAL HEALTH SERVICE CORPS

SEC. 101. (a)(1) Section 331(a)(1) (42 U.S.C. 254d(a)(1)) is amended to read as follows: "(1) shall consist of—

"(A) such officers of the Regular and Reserve Corps of the Service as the Secretary may designate,

"(B) such civilian employees of the United States as the Secretary may appoint, and

"(C) such other individuals who are not employees of the United States and who the Secretary has designated under section 752(b)(4) to serve in a health manpower shortage area as a member of the Corps to satisfy the service obligation described in section 751(f)(1)(B)(iv),

(such officers, employees, and individuals hereinafter in this subpart referred to as 'Corps members'), and".

(2)(A) Section 331(d)(1) is amended by inserting after "each member of the Corps" the following: "(other than a member described in subsection (a)(1)(C))".

(B) Section 331(d) is amended by adding at the end the following:

"(3) A member of the Corps described in subparagraph (C) of subsection (a)(1) shall when assigned to an entity under section 333 be subject to the personnel system of such entity, except that such member shall be entitled to receive during the period of assignment the income that the member would be entitled to receive if the member was a member of the Corps described in subparagraph (B) of such subsection.".

(3) Section 331(h)(1) is amended by striking out ", Education, and Welfare" and inserting in lieu thereof "and Human Services".

(b)(1) Subsection (a) of section 333 (42 U.S.C. 254f) is amended by adding at the end the following:

"(3) In approving applications for assignment of members of the Corps the Secretary shall not discriminate against applications from entities which are not receiving Federal financial assistance under this Act.".

(2) Section 333 is amended by redesignating subsections (d) through (h) as subsections (e) through (i), respectively, and by adding after subsection (c) the following new subsection:

"(d)(1) The Secretary may not approve an application for the assignment of a member of the Corps described in subparagraph (C) of section 331(a)(1)(C) to an entity unless the application of the entity contains assurances satisfactory to the Secretary that the entity (A) has sufficient financial resources to provide the member of the Corps with an income of not less than the income to which the member would be entitled if the member was a member described in subparagraph (B) of section 331(a)(1), or (B) would have such financial resources if a grant was made to the entity under paragraph (2).

"(2)(A) If in approving an application of an entity for the assignment of a member of the Corps described in subparagraph (C) of section 331(a)(1) the Secretary determines that the entity does not have sufficient financial resources to provide the member of the Corps with an income of not less than the income to which the member would be entitled if the member was a member described in subparagraph (B) of section 331(a)(1), the Secretary may make a grant to the entity to assure that the member of the Corps assigned to it will receive during the period of assignment to the entity such an income.

"(B) The amount of any grant under subparagraph (A) shall be determined by the Secretary. Payments under such a grant may be made in advance or by way of reimbursement, and at such intervals and on such conditions, as the Secretary finds necessary. No grant may be made unless an application therefor is submitted to and approved by the Secretary. Such an application should be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe.".

(3) Subsection (g) (as so redesignated) of section 333 is amended by adding at the end the following:

"(4) The Secretary shall conduct programs to demonstrate the improvements that can be made in the assignment of members of the Corps to health manpower shortage areas and in the delivery of health care by Corps members in such areas through coordination with State and local governments and other public and nonprofit private entities with expertise in the planning, development, and operation of centers for the delivery of primary health care. Demonstration programs under this paragraph shall at least include a program under which the Secretary enters into an agreement with a State which provides that if the State places in effect, in accordance with standards prescribed by regulation by the Secretary, a program for the planning, development, and operation of centers for the delivery of primary health care in health manpower shortage areas in the State, the Secretary will assign under this section members of the Corps to entities within the State in accordance with the State program.".

(c)(1) Section 334(a) (42 U.S.C. 254g(a)) is amended by inserting "for the assignment of a member of the Corps" after "section 333".

(2) Section 334(a)(3)(A) is amended by inserting "from the United States" after "received by such member".

(3) Section 334(a)(3)(C) is amended (1) by inserting "or a grant under section 333(d)(2)" after "section 335(c)", and (2) by inserting "or grant" after "loan" each time it occurs.

(4) Subsection (e) of section 334 is amended to read as follows:

"(e)(1) There is established in the Treasury of the United States a revolving fund to be called the National Health Service Corps Fund (hereinafter in this subsection referred to as the 'Fund') which shall be available to the Secretary, without fiscal year limitation, to carry out this subpart.

"(2) There shall be deposited in the Fund, subject to withdrawal by check by the Secretary—

"(A) funds received by the Secretary after September 30, 1980, under an agreement entered into under subsection (a), and

"(B) interest which may be earned on investments of the Fund.

"(3) If the Secretary determines that the moneys of the Fund are in excess of current needs, the Secretary may request the investment of such amounts as the Secretary deems advisable by the Secretary of the Treasury in obligations of, or obligations guaranteed by, the Government of the United States, and, with the approval of the Secretary of the Treasury, in such other obligations or securities as it deems appropriate.

"(4) With the approval of the Secretary of the Treasury, the Secretary of Health and Human Services may deposit moneys in the Fund in any Federal Reserve bank, any depository for public funds, or in such other places and in such manner as the Secretary of Health and Human Services and the Secretary of the Treasury may mutually agree.

"(5) The Fund and the funds credited to it shall not be subject to apportionment under section 3679 of the Revised Statutes (31 U.S.C. 665).".

(d)(1) Subpart II of part D of title III is amended by redesignating sections 336, 337, and 338 as sections 338, 338A, and 338B, respectively; by transferring section 755 to the subpart, inserting such section after section 335, and redesignating it as section 336; and by adding after section 336 (as so redesignated) the following new section:

"PREPARATION FOR PRACTICE

"SEC. 337. (a) The Secretary may make grants and enter into contracts with public and private nonprofit entities for the conduct of programs which are designed to prepare individuals subject to a service obligation under the Scholarship Program to effectively provide health services in the health manpower shortage area to which they are assigned.

"(b) No grant may be made or contract entered into under subsection (a) unless an application therefor is submitted to and approved by the Secretary. Such an application should be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe.".

(2) Subsection (a)(1) of section 336 (as so redesignated) is amended by inserting "at least two years of" after "completed".

(e) Section 338B(a) (as so redesignated) (42 U.S.C. 254k) is amended (1) by striking out "and" after "1979;", and (2) by adding before the period a semicolon and the following: "$133,000,000 for the fiscal year ending September 30, 1981, $206,000,000 for the fiscal year ending September 30, 1982, and $246,000,000 for the fiscal year ending September 30, 1983".

REVISION OF NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP PROGRAM

SEC. 102. (a)(1) Section 751(a) is amended by striking out "for the National Health Service Corps" and inserting in lieu thereof "for the programs of the National Health Service Corps".

(2) Sections 751(b)(2) and 751(c)(2) are each amended by striking out "service in the Corps" and inserting in lieu thereof "service in the programs of the Corps".

(b)(1) Paragraphs (1) through (4) of section 752(b) (42 U.S.C. 294u(b)) are amended to read as follows:

"(b)(1) If an individual is required under subsection (a) to provide service as specified in section 751(f)(1)(B)(iv) (hereinafter in this subsection referred to as 'obligated service'), the Secretary shall, not later than 90 days before the date described in paragraph (5), determine if the individual shall provide such service—

"(A) as a member of the Corps who is a commissioned officer in the Regular or Reserve Corps of the Service or who is a civilian employee of the United States, or

"(B) as a member of the Corps who is not such an officer or employee,

and shall notify such individual of such determination.

"(2) If the Secretary determines that an individual shall provide obligated service as a member of the Corps who is a commissioned officer in the Service or a civilian employee of the United States, the Secretary shall, not later than 60 days before the date described in paragraph (5), provide such individual with sufficient information regarding the advantages and disadvantages of service as such a commissioned officer or civilian employee to enable the individual to make a decision on an informed basis. To be eligible to provide obligated service as a commissioned officer in the Service, an individual shall notify the Secretary, not later than 30 days before the date described in paragraph (5), of the individual's desire to provide such service as such an officer. If an individual qualifies for an appointment as such an officer, the Secretary shall, as soon as possible after the date described in paragraph (5), appoint the individual as a commissioned officer of the Regular or Reserve Corps of the Service and shall designate the individual as a member of the Corps.

"(3) If an individual provided notice by the Secretary under paragraph (2) does not qualify for appointment as a commissioned officer in the Service; the Secretary shall appoint such individual as a civilian employee of the United States and designate the individual as a member of the Corps.

"(4) If the Secretary determines that an individual shall provide obligated service as a member of the Corps who is not an employee of the United States, the Secretary shall as soon as possible after the date described in paragraph (5), designate such individual as a member of the Corps to provide such service.".

(2) Subsection (c)(1) of section 752 is amended by striking out "or as a member of the Corps" and inserting in lieu thereof "or as a civilian employee of the United States or is designated as a member of the National Health Service Corps under subsection (b)(4)".

(3) The second sentence of subsection (d) of section 752 is amended by inserting after "written contract" the follow-

ing: "and if such individual is an officer in the Service or a civilian employee of the United States".

(4) Subsection (e) of section 752 is amended to read as follows:

"(e) Notwithstanding any other provision of this title, service of an individual under a National Research Service Award awarded under subparagraph (A) or (B) of section 472(a)(1) shall be counted against the obligated service which the individual is required to perform under the Scholarship Program.".

(c)(1) Subsection (a) of section 753 (42 U.S.C. 294v(a)) is amended (A) by inserting "or under section 225 (as in effect on September 30, 1977)" after "section 752(a)", and (B) by striking out "which (A)" and all that follows in that subsection and inserting in lieu thereof a period.

(2) Section 753(b)(1)(B) is amended (A) by inserting "(i)" before "shall not", and (B) by inserting before the semicolon a comma and the following: "and (ii) shall agree to accept an assignment under section 1842(b)(3)(B)(ii) of such Act for all services for which payment may be made under part B of title XVIII and enter into an appropriate agreement with the State agency which administers the State plan for medical assistance under title XIX of such Act to provide services to individuals entitled to medical assistance under the plan".

(3) Section 753 is amended by adding the following new subsection:

"(c) If an individual breaches the contract entered into under section 751 by failing (for any reason) to begin his service obligation in accordance with an agreement entered into under subsection (a) or to complete such service obligation, the Secretary may require such individual to perform such service obligation as a member of the Corps."

(4) Section 754(c) (42 U.S.C. 294w(c)) is amended (1) by striking out "(c) If" and inserting in lieu thereof "(c)(1) Except as provided in paragraph (2), if", and (2) by adding at the end the following:

"(2) If an individual is released under section 753 from a service obligation under section 225 (as in effect on September 30, 1977) and if the individual does not meet the service obligation incurred under section 753, subsection (f) of such section 225 shall apply to such individual in lieu of paragraph (1) of this subsection.".

(d)(1) The first sentence of section 756(a) is amended (A) by striking out "and" after "1979," and (B) by inserting before the period, the following: ", $93,500,000 for the fiscal year ending September 30, 1981, $101,000,000 for the fiscal year ending September 30, 1982, and $109,000,000 for the fiscal year ending September 30, 1983".

(2) The second sentence of such section is amended (1) by striking out "1981" and inserting in lieu thereof "1984", and (2) by striking out "1980" and inserting in lieu thereof "1983".

EFFECTIVE DATE

SEC. 103. The amendments made by section 102 (other than subsection (d) thereof) shall apply with respect to contracts entered into under the National Health Service Corps Scholarship Program under subpart III of part C of title VII of the Public Health Service Act after the date of the enactment of this Act. An individual who before such date has entered into such a contract and who has not begun the period of obligated service required under such contract shall be given the opportunity to revise such contract to permit the individual to serve such period as a member of the National Health Service Corps who is not an employee of the United States.

TITLE II—HEALTH PROFESSIONS PROGRAMS UNDER TITLE VII

PART A—CONSTRUCTION ASSISTANCE

REPEAL OF ENROLLMENT INCREASE REQUIREMENT

SEC. 201. (a) Paragraph (2) of section 721(c) is amended (1) by inserting "and" after "the facility,", and (2) by striking out ", and (D)" and all that follows in that paragraph and inserting in lieu thereof a semicolon.

(b) The amendment made by subsection (a) shall apply with respect to entities which received a grant under section 720 of the Public Health Service Act before the date of the enactment of this Act.

LOAN GUARANTEES

SEC. 202. Section 726(a) (42 U.S.C. 293i(a)) is amended (1) by striking out "construction projects for" in the first sentence and inserting in lieu thereof "projects for the remodeling, renovation, or alteration of", (2) by striking out "1980" and inserting in lieu thereof "1983", and (3) by striking out "cost of the construction of the project" in the last sentence and inserting in lieu thereof "cost of the project, including architect fees and the initial equipment of the remodeled, renovated, or altered teaching facilities".

PART B—STUDENT ASSISTANCE

EXTENSION AND REVISION OF INSURED STUDENT LOAN PROGRAM

SEC. 205. (a)(1) The first sentence of section 728(a) (42 U.S.C. 294a(a)) is amended by inserting a comma before the period and the following: "and for each of the next three fiscal years".

(2) The second sentence of such section is amended by striking out "1982" and inserting in lieu thereof "1985".

(b)(1) Section 731(a)(1)(A) (42 U.S.C. 294d(a)(1)(A)) is amended (A) by inserting "and" at the end of clause (iv), and

(B) by striking out clause (v) and redesignating clause (vi) as clause (v).

(2) Section 731(a)(2) is amended (A) by striking out "installments of principal need not be paid, but interest shall accrue and be paid" in subparagraph (C) and inserting in lieu thereof "installments of principal and interest need not be paid, but interest shall accrue", (B) by inserting "except as provided in subparagraph (C)," after "period of the loan," in subparagraph (D), and (C) by striking out "otherwise payable (i) before the beginning of the repayment period, (ii) during any period described in subparagraph (C), or (iii) during any other period of forbearance of payment of principal," in subparagraph (D).

(3) Section 731(a)(2) is amended (A) by redesignating subparagraphs (E) and (F) as subparagraphs (F) and (G), and (B) by inserting after subparagraph (D) the following:

> "(E) offers, in accordance with criteria prescribed by regulation by the Secretary, a schedule for repayment of principal and interest under which payment of a portion of the principal and interest otherwise payable at the beginning of the repayment period (as defined in such regulations) is deferred until a later time in the period;".

(4) Section 739(b) is amended to read as follows:

"(b) The Secretary shall require an eligible institution to record, and to make available to the lender and to the Secretary upon request, the name, address, postgraduate destination, and other reasonable identifying information for each student of such institution who has a loan insured under this subpart.".

EXTENSION OF STUDENT LOAN PROGRAM

SEC. 206. (a)(1) The first sentence of section 742(a) (42 U.S.C. 294b(a)) is amended (1) by striking out "and" after "1979,", and (2) by inserting before the period a comma and the following: "$20,000,000 for the fiscal year ending September 30, 1981, $22,500,000 for the fiscal year ending September 30, 1982, and $25,000,000 for the fiscal year ending September 30, 1983".

(2) The second sentence of such section is amended (A) by striking out "1981" and inserting in lieu thereof "1984", and (B) by striking out "1980" and inserting in lieu thereof "1983".

(b) Section 743 (42 U.S.C. 294c) is amended by striking out "1983" each place it occurs and inserting in lieu thereof "1986".

EXTENSION OF SCHOLARSHIPS FOR STUDENTS OF EXCEPTIONAL FINANCIAL NEED

SEC. 207. (a) Section 758(d) (42 U.S.C. 294z(d)) is amended (1) by striking out "and" after "1979,", and (2) by inserting before the period a comma and the following: "$12,000,000 for the fiscal year ending September 30, 1981, $14,000,000 for the fiscal year ending September 30, 1982, and $16,000,000 for the fiscal year ending September 30, 1983".

(b) Section 758(c) is amended by striking out "distribute grants under this section among all schools of the health professions, but shall".

Part C—Institutional Support

GRANTS

Sec. 211. Section 770 (42 U.S.C. 295f) is amended to read as follows:

"INSTITUTIONAL SUPPORT

"Sec. 770. (a) Grants.—The Secretary shall make annual grants in accordance with this section to schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, and podiatry for the support of the education programs of such schools.

"(b) Grant Computation.—The amount of the annual grant under subsection (a) to be made in a fiscal year to a school with an approved application for such fiscal year shall be an amount which bears the same ratio to the total amount appropriated for such fiscal year under subsection (d) as the total number of full-time students enrolled in such school in the school year beginning in such fiscal year bears to the total number of full-time students enrolled in such school year in all schools of the same category as such school with approved applications for such fiscal year.

"(c) ENROLLMENT DETERMINATIONS.—For purposes of this section:

"(1) Regulations of the Secretary under this section relating to the determination of the number of full-time students enrolled in a school eligible for a grant under subsection (a) shall include (A) provisions relating to the determination of such number on the basis of estimates, on the basis of the number of students who in an earlier year were enrolled in a school, or on such other basis as the Secretary deems appropriate for making such determination, and (B) methods of making such determination when a school was not in existence in an earlier year.

"(2) In determining the total number of full-time students enrolled in a school of pharmacy with a course of study of more than four years, only the full-time students enrolled in the last four years of such school shall be counted.

"(3) The term 'full-time students' (whether such term is used by itself or in connection with a particular year-class) means students pursuing a full-time course of study leading to a degree of doctor of medicine, doctor of dentistry or an equivalent degree, doctor of osteopathy, bachelor or master of science in pharmacy or an equivalent degree, doctor of optometry or an equivalent degree, doctor of veterinary medicine or an equivalent degree, or doctor of podiatry or an equivalent degree. In the case of a training program of a school designed to permit the students enrolled in such program to complete, within six years after completing secondary school, the requirements for degree of doctor of medicine, doctor of dentistry or an equivalent degree, or doctor of osteopthy, the term 'full-time students' shall only include students enrolled on a full-time basis in the last four years of such program.

"(d) AUTHORIZATIONS OF APPROPRIATIONS.—There are authorized to be appropriated—

"(1) $70,000,000 for the fiscal year ending September 30, 1981, $77,000,000 for the fiscal year ending September 30, 1982, and $85,000,000 for the fiscal year ending September 30, 1983, for payments under grants under subsection (a) for schools of medicine;

"(2) $5,000,000 for the fiscal year ending September 30, 1981, $5,500,000 for the fiscal year ending September 30, 1982, and $6,000,000 for the fiscal year ending September 30, 1983, for payments under grants under subsection (a) for schools of osteopathy;

"(3) $23,500,000 for the fiscal year ending September 30, 1981, $26,000,000 for the fiscal year ending September 30, 1982, and $28,500,000 for the fiscal year ending September 30, 1983, for payments under grants under subsection (a) for schools of dentistry;

"(4) $5,500,000 for the fiscal year ending September 30, 1981, $6,000,000 for the fiscal year ending September 30, 1982, and $6,700,000 for the fiscal year ending September 30, 1983, for payments under grants under subsection (a) for schools of veterinary medicine;

"(5) $1,700,000 for the fiscal year ending September 30, 1981, $1,900,000 for the fiscal year ending September 30, 1982, and $2,100,000 for the fiscal year ending September 30, 1983, for payments under grants under subsection (a) for schools of optometry;

"(6) $8,700,000 for the fiscal year ending September 30, 1981, $9,600,000 for the fiscal year ending September 30, 1982, and $10,500,000 for the fiscal year ending September 30, 1983, for payments under grants under subsection (a) for schools of pharmacy;

"(7) $1,200,000 for the fiscal year ending September 30, 1981, $1,300,000 for the fiscal year ending September 30, 1982, and $1,500,000 for the fiscal year ending September 30, 1983, for payments under grants under subsection (a) for schools of podiatry.".

GRANT REQUIREMENTS

SEC. 212. (a)(1) Effective with respect to grants made under section 770 of the Public Health Service Act for the fiscal year ending September 30, 1980, section 771(a)(1) (42 U.S.C. 295f-1(a)(1)) is amended by inserting after "first-year enrollment" the following: "(determined without regard to any increase in such enrollment made by the school to enable it to qualify for financial assistance under chapter 82 of title 38, United States Code)".

(2) Effective with respect to grants made under section 770 of the Public Health Service Act for fiscal years beginning after September 30, 1980, subsection (a) of section 771 (42 U.S.C. 295f-1) is amended to read as follows:

"SEC. 771. (a) IN GENERAL.— The Secretary shall not make a grant under section 770(a) to any school in a fiscal year beginning after September 30, 1980, unless the application for the grant contains, or is supported by, assurances satisfactory to the Secretary that the applicant will expend in carrying out its functions as a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, or podiatry, as the case may be, during the fiscal year for which such grant is sought, an amount of funds (other than funds for construction as determined by the Secretary) from non-Federal sources which is at least as great as the amount of funds expended by such applicant for such purpose (excluding expenditures of a nonrecurring nature) in the fiscal year preceding the fiscal year for which such grant is sought.".

(b)(1) Subsection (b)(1) of section 771 is amended by striking out "paragraphs (2) and (3)" and inserting in lieu thereof "paragraph (2)".

(2)(A) Subsection (b)(2)(A)(i) of section 771 is amended (i) by striking out "1977" and inserting in lieu thereof "1980", (ii) by striking out "35 percent" and inserting in lieu thereof "30 percent", and (C) by striking out "1978" each place it occurs and inserting in lieu thereof "1981".

(B) Subsection (b)(2)(A)(ii) of section 771 is amended (i) by striking out "1978" and inserting in lieu thereof "1981", (ii) by striking out "40 percent" and inserting in lieu thereof "35 percent", and (iii) by striking out "1979" each place it occurs and inserting in lieu thereof "1982".

(C) Subsection (b)(2)(A)(iii) of section 771 is amended (i) by striking out "1979" and inserting in lieu thereof "1982", and (ii) by striking out "50 percent" and inserting in lieu thereof "40 percent".

(3)(A) The second sentence of subsection (b)(2)(B) of section 771 is amended (i) by inserting "(i)" after "deduct from such number", and (ii) by inserting before the period a comma and the following "and (ii) a number equal to the number of filled first-year positions in graduate medical education programs in subspecialties of internal medicine or pediatrics as of the July 15 for which the determination is to be made under this sentence".

(B) The first sentence of subsection (b)(2)(C) of section 771 is amended (i) by inserting "(i)" after "shall be reduced by", and (ii) by inserting before the period a comma and the following "and (ii) the number of filled first-year positions in graduate medical education programs of such school in subspecialties of internal medicine or pediatrics as of the July 15 for which the determination is to be made under this sentence".

(c) Subsection (e) of section 771 is repealed and subsections (f), (g), (h), and (i) are redesignated as subsections (e), (f), (g), and (h).

(d)(1) Subsection (b) of section 772 (42 U.S.C. 295f–5) is amended by striking out "or subsection (a) or (b) of section 788".

(2)(A) The first sentence of section 788(a)(3) (42 U.S.C. 295g–8(a)(3)) is amended by inserting "and the applicant meets the requirements of subsection (b) of section 772" before the period.

(B) Section 788(b)(3) is amended by inserting before the first sentence the following: "No grant may be made under paragraph (1) unless an application therefor has been submitted to and approved by the Secretary and the applicant meets the requirements of subsection (b) of section 772.".

(3) Paragraph (2) of subsection (d) of section 772 is amended by striking out "under the section authorizing the grant for which the application is made" and inserting in lieu thereof "under section 770".

(e)(1) The heading for section 771 is amended to read as follows:

"ELIGIBILITY FOR INSTITUTIONAL SUPPORT".

(2) The heading for section 772 is amended to read as follows:

"APPLICATIONS FOR INSTITUTIONAL SUPPORT".

PART D—PROJECT GRANTS AND CONTRACTS

DEPARTMENTS OF FAMILY MEDICINE

SEC. 215. Section 780(c) (42 U.S.C. 295g(c)) is amended (1) by striking out "and" after "1979,", and (2) by inserting after "1980" the following: ", $15,000,000 for the fiscal year ending September 30, 1981, $20,000,000 for the fiscal year ending September 30, 1982, and $25,000,000 for the fiscal year ending September 30, 1983".

AREA HEALTH EDUCATION CENTERS

SEC. 216. (a) Section 781(g) is amended (1) by striking out "and" after "1979,", and (2) by inserting after "1980" the following: ", $21,000,000 for the fiscal year ending September 30, 1981, $25,000,000 for the fiscal year ending September 30, 1982, and $27,000,000 for the fiscal year ending September 30, 1983".

(b) The last sentence of section 781(c) (42 U.S.C. 295g-1(c)) is amended by striking out "paragraph (3)" and inserting in lieu thereof "paragraph (2) or (3)".

(c) Section 781(d)(2)(E) is amended by striking out "support services" and inserting in lieu thereof "educational support services".

(d) The authority to enter into contracts under section 781 of the Public Health Service Act is not authority to enter into cooperative agreements under that section.

PHYSICIAN ASSISTANTS AND DENTAL AUXILIARIES

SEC. 217. (a) Section 783(e) (42 U.S.C. 295g-3(e)) is amended (1) by striking out "and" after "1979,", and (2) by inserting after "1980" the following: ", $14,000,000 for the fiscal year ending September 30, 1981, $15,000,000 for the fiscal year ending September 30, 1982, and $16,000,000 for the fiscal year ending September 30, 1983".

(b) Section 783(c) is amended by striking out "830" and inserting in lieu thereof "822".

GENERAL INTERNAL MEDICINE AND GENERAL PEDIATRICS

SEC. 218. (a) Section 784(b) (42 U.S.C. 295g-4(b)) is amended (1) by striking out "and" after "1979,", and (2) by inserting after "1980" the following: ", $23,000,000 for the fiscal year ending September 30, 1981, $30,000,000 for the fiscal year ending September 30, 1982, and $32,000,000 for the fiscal year ending September 30, 1983".

(b) Section 784(a) is amended—

(1) by inserting ", public or private nonprofit hospital, or any other public or private nonprofit entity" after "osteopathy"; and

(2) by striking out "and" at the end of paragraph (1), by striking out the period at the end of paragraph (2) and inserting a semicolon, and by adding at the end the following:

"(3) to plan, develop, and operate a program for the training of physicians who plan to teach in general internal medicine and general pediatrics training programs; and

"(4) to provide assistance (in the form of traineeships and fellowships) to physicians who are participants in any such program.".

FAMILY MEDICINE AND GENERAL PRACTICE OF DENTISTRY

SEC. 219. (a) Section 786(d) (42 U.S.C. 295g-6(d)) is amended (1) by striking out "and" after "1979,", and (2) by inserting after "1980" the following: ", $50,000,000 for the fiscal year ending September 30, 1981, $75,000,000 for the fiscal year ending September 30, 1982, and $80,000,000 for the fiscal year ending September 30, 1983".

(b) The Secretary of Health and Human Services shall conduct a study to determine the most effective and efficient means of providing financial assistance to graduate medical education programs in the United States in primary medicine, pediatrics, and family medicine. The Secretary shall complete such study and report, not later than one year after the date of the enactment of this Act, to the Committee on Interstate and Foreign Commerce of the House of Representatives and the Committee on Labor and Human Resources of the Senate the results of the study and recommendations, if any, for legislation.

ASSISTANCE TO INDIVIDUALS FROM DISADVANTAGED BACKGROUNDS

SEC. 220. Section 787(b) (42 U.S.C. 295g-7(b)) is amended (1) by striking out "and" after "1979,", and (2) by inserting after "1980" the following: ", $25,000,000 for the fiscal year ending September 30, 1981, $27,500,000 for the fiscal year ending September 30, 1982, and $30,000,000 for the fiscal year ending September 30, 1983".

STARTUP, FINANCIAL DISTRESS, INTERDISCIPLINARY TRAINING, AND CURRICULUM GRANTS

SEC. 221. (a)(1) Section 788(a)(1) (42 U.S.C. 295g–8) is amended by striking out "medicine, osteopathy, dentistry".

(2) The amendment made by paragraph (1) shall not apply with respect to a school of medicine, osteopathy, or dentistry which received a grant under section 788(a)(1) of the Public Health Service Act for the fiscal year ending September 30, 1980. Such a school may continue to receive grants under such section in accordance with the requirements in effect for grants under the section for such fiscal year.

(b) Section 788(e)(1) is amended (1) by striking out "and" after "1979,", and (2) by inserting after "1980" the following: ", $20,000,000 for the fiscal year ending September 30, 1981, $22,500,000 for the fiscal year ending September 30, 1982, and $25,000,000 for the fiscal year ending September 30, 1983".

(c)(1) Subsection (c), (f), and (g) of section 788 are repealed and subsections (d) and (e) are redesignated as subsections (c) and (d), respectively.

(2) Subsection (d)(1) (as so redesignated) of section 788 is amended by striking out "(other than the provisions of subsections (f) and (g))".

PART E—PUBLIC HEALTH PERSONNEL

INSTITUTIONAL SUPPORT, TRAINEESHIPS, AND OTHER PROGRAMS

SEC. 230. Subpart I of part G of title VII is amended as follows:

(1) The following section is inserted at the beginning of the subpart:

"INSTITUTIONAL SUPPORT

"SEC. 791. (a) GRANTS.—The Secretary shall make annual grants in accordance with this section to public and other nonprofit schools of public health.

"(b) GRANT COMPUTATION.—The amount of the annual grant under subsection (a) to be made in a fiscal year to a school with an approved application for such fiscal year shall be an amount which bears the same ratio to the total amount appropriated for such fiscal year under subsection (d) as the sum of—

"(1) the total number of full-time students enrolled in such school in the school year beginning in such fiscal year, and

"(2) the number of full-time equivalents of part-time students in such school for such school year, bears to the sum of the total number of full-time students enrolled in such school year and the number of such full-time equivalents for such school year in all schools of public health with approved applications for such fiscal year.

"(c) ENROLLMENT DETERMINATIONS.—For purposes of this section:

"(1) Section 770(c) shall apply to regulations of the Secretary under this section relating to the determination of the number of full-time students enrolled in a school eligible for a grant under subsection (a).

"(2) The number of full-time equivalents of part-time students in a school of public health for any school year is a number equal to—

"(A) the total number of credit hours of instruction in such year for which part-time students in such school, who are pursuing a course of study leading to a graduate degree in public health or an equivalent degree, have enrolled, divided by

"(B) the greater of (i) the number of credit hours of instruction which a full-time student in such school was required to take in such year, or (ii) 9,

rounded to the next highest whole number.

"(3) The term 'full-time students' (whether such term is used by itself or in connection with a particular year-class) means students pursuing a full-time course of study leading to a graduate degree in public health or an equivalent degree.

"(d) Authorizations of Appropriations.—For the purpose of making grants under subsection (a) there are authorized to be appropriated $7,000,000 for the fiscal year ending September 30, 1981, $8,000,000 for the fiscal year ending September 30, 1982, and $9,000,000 for the fiscal year ending September 30, 1983.

"(e) Grant Requirements.—The Secretary shall not make a grant under subsection (a) to any school in a fiscal year beginning after September 30, 1980, unless—

"(1) the application for the grant contains, or is supported by, assurances satisfactory to the Secretary that the applicant will expend in carrying out its functions as a school of public health during the fiscal year for which such grant is sought, an amount of funds (other than funds for construction as determined by the Secretary) from non-Federal sources which is at least as great as the amount of funds expended by such applicant for such purpose (excluding expenditures of a nonrecurring nature) in the fiscal year preceding the fiscal year for which such grant is sought; and

"(2) the school maintains an enrollment of full-time first-year students, for the school year beginning in the fiscal year for which a grant under subsection (a) is sought, which exceeds the number of full-time students enrolled in such school in the school year beginning in the fiscal year ending September 30, 1979—

"(A) by 5 percent of such number if such number was not more than 100, or

"(B) by 2.5 percent of such number, or 5 students, whichever is greater, if such number was more than 100.

The Secretary may waive (in whole or in part) application of the requirements of paragraph (2) to a school if the Secretary determines, after receiving the written recommendation of the appropriate accreditation body or bodies (approved for such purposes by the Secretary of Education) that compliance by such school with such requirement will prevent it from maintaining its accreditation.

"(f) APPLICATIONS.—

"(1) No grant may be made under subsection (a) unless an application therefor is submitted to and approved by the Secretary. The Secretary may from time to time set dates (not earlier than in the fiscal year preceding the year for which a grant is sought) by which such applications must be filed.

"(2) To be eligible for a grant under subsection (a) the applicant must be accredited as determined in accordance with section 772(b).

"(3) The Secretary shall not approve or disapprove any application for a grant under subsection (a) except after consultation with the National Advisory Council on Health Professions Education (established by section 702).

"(4) A grant under subsection (a) may be made only if the application therefor—

"(A) is approved by the Secretary upon his determination that the applicant (and its application) meet the eligibility conditions prescribed by subsection (e) and paragraph (2) of this subsection;

"(B) contains such additional information as the Secretary may require to make the determinations required of him under subsection (a); and

"(C) provides for such fiscal control and accounting procedures and reports, including the use of such standard procedures for the recording and reporting of financial information as the Secretary may prescribe, and access to the records of the applicant, as the Secretary may require to enable him to determine the costs to the applicant of its program for the education or training of students.".

(2) Section 748 is transferred to the subpart, inserted after the section 791 added by paragraph (1), redesignated as section 792, in subsection (a)(2) amended by striking out "749" and inserting in lieu thereof "794B", and in subsection (c) amended (A) by striking out "and" after "1979;", and (B) by inserting before the period a semicolon and the following: "$8,000,000 for the fiscal year ending September 30, 1981, $9,000,000 for the fiscal year ending September 30, 1982, and $10,000,000 for the fiscal year ending September 30, 1983".

(3) The section 792 entitled "Special Projects for Accredited Schools of Public Health and Graduate Programs in Health Administration" is inserted after the section inserted by paragraph (2), redesignated as section 793, and in subsection (c) amended (A) by striking out "and" after "1979;", and (B) by inserting after "1980" the following: "; $5,000,000 for the fiscal year ending September 30, 1981; $5,500,000 for the fiscal year ending September 30, 1982; and $6,000,000 for the fiscal year ending September 30, 1983".

(4) The following section is inserted after section 793 (as so redesignated):

"MIDCAREER TRAINING AND EDUCATION

"SEC. 794. (a) The Secretay may make grants to and enter into contracts with public and nonprofit private entities for the establishment, operation, and administration of centers to provide intensive, short-term, advanced training, to individuals with demonstrated expertise in health policy and management, in—

"(1) health systems management,

"(2) health policy, planning, and regulation,

"(3) environmental policy and management,

"(4) financial management and strategy in health care,

"(5) the management of collaboration between health care entities,

"(6) the management of small health care entities in inner cities and rural areas, and

"(7) other matters which will increase the capabilities of such individuals and broaden their perspectives in carrying out their functions.

"(b)(1) The amount of any grant or contract under subsection (a) shall be determined by the Secretary. No grant may be made or contract entered into unless an application therefor is submitted to and approved by the Secretary. Such an application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe.

"(2) The Secretary shall, to the extent feasible, make grants and enter into contracts under subsection (a) for centers in such a manner that there is an appropriate geographic distribution of the centers.

"(c) For the purposes of making grants and contracts under subsection (a) there are authorized to be appropriated $1,500,000 for the fiscal year ending September 30, 1981, $2,500,000 for the fiscal year ending September 30, 1982, and $3,000,000 for the fiscal year ending September 30, 1983.".

(5) The section 791 entitled "Grants for Graduate Programs in Health Administration" is inserted after the section added by paragraph (4), redesignated as section 794A, and in subsection (d) amended (A) by striking out "and" after "1979,", and (B) by inserting after "1980" the following: ", $3,000,000 for the fiscal year ending September 30, 1981, $3,250,000 for the fiscal year ending September 30, 1982, and $3,500,000 for the fiscal year ending September 30, 1983".

(6) Section 749 is inserted after the section inserted by paragraph (5), redesignated as section 794B, and in subsection (c) amended (A) by striking out "and" after "1979;", and (B) by inserting before the period a semicolon and the

following: "$2,500,000 for the fiscal year ending September 30, 1981, $3,000,000 for the fiscal year ending September 30, 1982, and $3,500,000 for the fiscal year ending September 30, 1983".

(7) The following sections are inserted after section 749B (as so redesignated):

"GRANTS TO DEPARTMENTS OF PREVENTIVE OR COMMUNITY MEDICINE OR DENTISTRY

"SEC. 794C. (a) The Secretary may make grants to schools of medicine, dentistry, and osteopathy for the costs of projects—

"(1) to establish, maintain, and improve academic administrative units in preventive or community medicine or dentistry;

"(2) to improve predoctoral and postdoctoral instruction in preventive, community, or occupational medicine or dentistry;

"(3) to plan, develop, and operate joint programs between academic administrative units in preventive or community medicine or dentistry and such units in other clinical specialties which integrate the teaching of clinical preventive, community, or occupational medicine or dentistry within clinical programs for other medical or dental disciplines; and

"(4) to plan, develop, and operate special programs to train teachers and researchers in the fields of preventive, community, or occupational medicine or dentistry.

"(b)(1) The amount of any grant under subsection (a) shall be determined by the Secretary. No grant may be made unless an application therefor is submitted to and approved by the Secretary. Such an application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe.

"(2) To be eligible for a grant under subsection (a), an applicant school must have, or demonstrate an intention to establish, an academic administrative unit in preventive or community medicine or dentistry or an academic or administrative unit which has the primary responsibility, within that medical, dental, or osteopathic school, for teaching the principles of preventive or community medicine or dentistry.

"(c) For payments under grants under subsection (a), there is authorized to be appropriated $2,000,000 for the fiscal year ending September 30, 1981; $3,000,000 for the fiscal year ending September 30, 1982; and $4,000,000 for the fiscal year ending September 30, 1983.

"TRAINING IN PREVENTIVE MEDICINE

"SEC. 794D. (a) The Secretary may make grants to schools of medicine and schools of public health to meet the costs of projects—

"(1) to plan and develop new residency training programs and to develop and expand accredited residency training programs in preventive medicine; and

"(2) to provide financial assistance to residency trainees enrolled in such programs.

"(b)(1) The amount of any grant under subsection (a) shall be determined by the Secretary. No grant may be made unless an application therefor is submitted to and approved by the Secretary. Such an application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe.

"(2) To be eligible for a grant under this section, the applicant must demonstrate to the Secretary that it has or will have available full-time faculty members with training and experience in the fields of preventive medicine and support from other faculty members trained in public health and other relevant specialties and disciplines.

"(c) For payments under grants under subsection (a), there is authorized to be appropriated $6,000,000 for the fiscal year ending September 30, 1981; $7,000,000 for the fiscal year ending September 30, 1982; and $8,000,000 for the fiscal year ending September 30, 1983."

(8) The section 793 entitled "Statistics and Annual Report" is inserted after section 794D and redesignated as section 794E.

PART F—ALLIED HEALTH PERSONNEL

PROJECT GRANTS

SEC. 235. Section 796(d)(1) (42 U.S.C. 295h-5) is amended (1) by striking out "and" after "1979;", and (2) by inserting after "1980" the following: "; $9,000,000 for the fiscal year ending September 30, 1981; $9,500,000 for the fiscal year ending September 30, 1982; and $10,000,000 for the fiscal year ending September 30, 1983".

TRAINEESHIPS

SEC. 236. Section 797(c) (42 U.S.C. 295h-6) is amended (1) by striking out "and" after "1979;", and (2) by inserting after "1980" the following: "; $1,300,000 for the fiscal year ending September 30, 1981; $1,400,000 for the fiscal year ending September 30, 1982; and $1,500,000 for the fiscal year ending September 30, 1983".

ASSISTANCE TO DISADVANTAGED INDIVIDUALS

SEC. 237. Section 798(c) (42 U.S.C. 295h-7) is amended (1) by striking out "and" after "1979,", and (2) by inserting after "1980" the following: ", $1,000,000 for the fiscal year ending September 30, 1981, $1,000,000 for the fiscal year ending September 30, 1982, and $1,000,000 for the fiscal year ending September 30, 1983".

TITLE III—NURSE TRAINING

CONSTRUCTION

SEC. 301. (a)(1) Section 801 (42 U.S.C. 296) is amended (A) by inserting "in health manpower shortage areas designated under section 332" after "nursing", (B) by striking out "and" after "1978,", and (C) by inserting after "1980" the following: ", $1,000,000 for the fiscal year ending September 30, 1981, $1,000,000 for the fiscal year ending September 30, 1982, and $1,000,000 for the fiscal year ending September 30, 1983".

(2) Section 802(b)(1) (42 U.S.C. 296a(b)(1)) is amended by inserting "in a health manpower shortage area designated under section 332" before the semicolon.

(b) Section 805(a) (42 U.S.C. 296d(a)) is amended by striking out "1980" and inserting in lieu thereof "1983".

INSTITUTIONAL SUPPORT

SEC. 302. (a) Section 810(a) (42 U.S.C. 296e(a)) is amended by striking out paragraphs (1), (2), and (3) and inserting in lieu thereof the following:

"(1)(A) For the fiscal year ending September 30, 1981, each collegiate school of nursing shall receive an amount equal to the product of—

"(i) $200, and

"(ii) the sum of (I) the number of full-time students enrolled in each of the last two years of such school in the fiscal year for which the grant is to be made, and (II) the number of full-time equivalents of part-time students for such school for such fiscal year.

"(B) For the fiscal year ending September 30, 1982, each collegiate school of nursing shall receive an amount equal to the product of $210 and the sum described in subparagraph (A)(ii).

"(C) For the fiscal year ending September 30, 1983, each collegiate school of nursing shall receive an amount equal to the product of $220 and the sum described in subparagraph (A)(ii).

"(2)(A) For the fiscal year ending September 30, 1981, each associate degree school of nursing and each diploma school of nursing shall receive an amount equal to the product of—

"(i) $200, and

"(ii) the sum of (I) the number of full-time students enrolled in such school in the fiscal year for which the grant is to be made, and (II) the number of full-time equivalents of part-time students for such school for such fiscal year.

"(B) For the fiscal year ending September 30, 1982, each such school of nursing shall receive an amount equal to the product of $210 and the sum described in subparagraph (A)(ii).

"(C) For the fiscal year ending September 30, 1983, each such school of nursing shall receive an amount equal to the product of $220 and the sum described in subparagraph (A)(ii).".

(b) Section 810(c)(2) is amended—

(1) in subparagraph (A), by striking out "June 30, 1975" and all that follows in that subparagraph and inserting in lieu thereof "September 30, 1979, by 5 percent or 5 students, whichever is greater.";

(2) by amending subparagraph (B) to read as follows:

"(B) In the case of a collegiate school of nursing, the school has provided reasonable assurances to the Secretary that it will carry out, in accordance with a plan submitted by the school to the Secretary and approved by the Secretary, in the school year beginning in the fiscal year in which such grant is to be made and in each school year thereafter beginning in a fiscal year in which such a grant is made, a program for the training of nurse practitioners (as defined in section 822)."; and

(3) by adding after subparagraph (B) the following:

"(C) The application of the school for such grant contains or is supported by reasonable assurances satisfactory to the Secretary that it will carry out, in accordance with a plan submitted by the school to the Secretary and approved by the Secretary, in the school year beginning in the fiscal year in which such grant is to be made and in each school year thereafter beginning in a fiscal year in which such a grant is made, a program to identify, recruit, enroll, retain, and graduate individuals from disadvantaged backgrounds (as determined in accordance with criteria prescribed by the Secretary) under which program at least 20 percent of each year's entering class (or ten students, whichever is greater) is comprised of such individuals.

"(D) In the case of a collegiate school of nursing, the application of the school for such grant contains or is supported by reasonable assurances satisfactory to the Secretary that in the school year beginning in the fiscal year in which such grant is to be made and in each school year thereafter beginning in a fiscal year in which such a grant is made at least 20 percent of each year's entering class of full-time students (or ten students, whichever is greater) shall be comprised of individuals who have a degree from an associate degree school of nursing or a diploma or equivalent indicia from a diploma school of nursing.

"(E) In the case of an associate degree school of nursing or a diploma school of nursing, the application of the school for such grant contains or is supported by reasonable assurances satisfactory to the Secretary that in the school year beginning in the fiscal year in which such grant is to be made and in each school year thereafter beginning in a fiscal year in which such a grant is made at least 20 percent of each year's entering class of full-time students (or ten students, whichever is greater) shall be comprised of individuals who are licensed practical or vocational nurses.

"(F) The application of the school for such grant contains or is supported by reasonable assurances satisfactory to the Secretary that in the school year beginning in the fiscal year in which such grant is to be made and in each school year thereafter beginning in a fiscal year in which such a grant is made the number of part-time students enrolled in the school in its program leading to the degree or diploma or equivalent indicia which it awards will be at least 20 percent of all the students enrolled in the school in such program.".

(c) Section 810(d) is amended (1) by striking out "part D" each place it occurs and inserting in lieu thereof "part B", and (2) by adding after paragraph (2) the following:

"(3) The number of full-time equivalents of part-time students for a school of nursing for any school year is a number equal to—

"(A) the total number of credit hours of instruction in such year for which part-time students of such school, who are pursuing a course of study leading to a degree or diploma or equivalent indicia, have enrolled, divided by

"(B) the number of credit hours of instruction which a full-time student of such school was required to take in such year,

rounded to the next highest whole number.".

(d) Section 810(f) is amended (1) by striking out "and" after "1978,", and (2) by inserting after "1980" the following: ", $25,000,000 for the fiscal year ending September 30, 1981, $27,500,000 for the fiscal year ending September 30, 1982, and $30,000,000 for the fiscal year ending September 30, 1983".

(e) The heading for section 810 is amended to read as follows:

"INSTITUTIONAL SUPPORT".

SPECIAL PROJECTS

SEC. 303. (a)(1) Section 820(a) (42 U.S.C. 296k(a)) is amended (A) by striking out paragraphs (1), (2), and (8), (B) by inserting "or" at the end of paragraph (6), (C) in paragraph (7) by striking out ", nursing assistants, and other paraprofessional nursing personnel; or" and inserting in lieu thereof a period, and (D) by redesignating paragraphs (3), (4), (5), (6), and (7) as paragraphs (1), (2), (3), (4), and (5), respectively.

(2) Notwithstanding the amendment made by paragraph (1), an entity which received a grant or contract under section 820(a) of the Public Health Service Act for the fiscal year ending September 30, 1980, for a project described in paragraph (1), (2), or (8) of such section may receive one additional grant or contract under such section for such project.

(b) Section 820(d) is amended—

(1) by striking out "and" after "1978,", and by inserting after "1980" the following: ", $15,000,000 for the fiscal year ending September 30, 1981, $17,500,000 for the fiscal year ending September 30, 1982, and $20,000,000 for the fiscal year ending September 30, 1983"; and

(2) by amending the last sentence to read as follows: "Of the funds appropriated under this subsection for any fiscal year beginning after September 30, 1980, not less than 20 percent of the funds shall be obligated for payments under grants and contracts for special projects described in subsection (a)(1) and not less than 20 percent of the funds shall be obligated for payments under grants and contracts for special projects described in subsection (a)(4).".

ADVANCED NURSE TRAINING

SEC. 304. (a) Section 821(a)(1) (42 U.S.C. 296l(a)(1)) is amended by striking out "to each" and inserting in lieu thereof "to teach".

(b) Section 821(b) is amended (1) by striking out "and" after "1978,", and (2) by inserting after "1980" the following: ", $12,000,000 for the fiscal year ending September 30, 1981, $13,500,000 for the fiscal year ending September 30, 1982, and $15,000,000 for the fiscal year ending September 30, 1983".

NURSE PRACTITIONER PROGRAMS

SEC. 305. (a) Section 822(b)(1) (42 U.S.C. 296m(b)(1)) is amended by striking out "who are residents of a health manpower shortage area (designated under section 332)" and inserting in lieu thereof a period and the following: "In considering applications for a grant or contract under this subsection, the Secretary shall give special consideration to applications for traineeships to train individuals who are residents of health manpower shortage areas designated under section 332.".

(b)(1) Section 822(b)(3) is amended by inserting before the period the following: "for a period equal to one month for each month for which the recipient receives such a traineeship".

(2) Section 822(b) is amended by adding after paragraph (3) the following:

"(4)(A) If, for any reason, an individual who received a traineeship under paragraph (1) fails to complete a service obligation under paragraph (3), such individual shall be liable for the payment of an amount equal to the cost of tuition and other education expenses and other payments paid under the traineeship, plus interest at the maximum legal prevailing rate.

"(B) When an individual who received a traineeship is academically dismissed or voluntarily terminates academic training, such individual shall be liable for repayment to the Government for an amount equal to the cost of tuition and other educational expenses paid to or for such individual from Federal funds plus any other payments which were received under the traineeship.

"(C) Any amount which the United States is entitled to recover under subparagraph (A) or (B) shall, within the three-year period beginning on the date the United States becomes entitled to recover such amount, be paid to the United States.

"(D) The Secretary shall by regulation provide for the waiver or suspension of any obligation under subparagraph (A) or (B) applicable to any individual whenever compliance by such individual is impossible or would involve extreme hardship to such individual and if enforcement of such obligation with respect to any individual would be against equity and good conscience.".

(3) The amendments made by paragraphs (1) and (2) shall apply with respect to traineeships which are awarded under section 822(b) of the Public Health Service Act after the date of the enactment of this Act.

(c) Section 822(e) is amended (1) by striking out "and" after "1978,", and (2) by inserting after "1980" the following: ", $17,000,000 for the fiscal year ending September 30, 1981, $18,500,000 for the fiscal year ending September 30, 1982, and $20,000,000 for the fiscal year ending September 30, 1983".

TRAINEESHIPS

SEC. 306. (a)(1) Subparagraph (C) of section 830(a)(1) (42 U.S.C. 297(a)(1)) is amended to read as follows:

"(C) to serve as nurse midwives, or".

(2) An individual who received a traineeship under section 830(a) of the Public Health Service Act for the fiscal year ending September 30, 1980, to receive training to serve as a nurse practitioner may, notwithstanding the amendment made by paragraph (1), receive additional traineeships under that section to complete the training to be a nurse practitioner.

(b) Section 830(b) is amended—

(1) by striking out "and" after "1978,", and by inserting after "1980" the following: ", $15,000,000 for the fiscal year ending September 30, 1981, $17,500,000 for the fiscal year ending September 30, 1982, and $20,000,000 for the fiscal year ending September 30, 1983"; and

(2) by adding at the end the following: "Not less than 50 percent of the funds appropriated under this subsection for any fiscal year shall be obligated for traineeships described in subsection (a)(1)(A), except that if the obligation of that amount of the funds appropriated under this subsection will prevent the Secretary from continuing a traineeship to an individual who received a traineeship under subsection (a) for the fiscal year ending September 30, 1980, the Secretary shall reduce the amount to be obligated for traineeships de-

scribed in subsection (a)(1)(A) by such amount as may be necessary for the continuation of traineeships first awarded in such fiscal year.".

NURSE ANESTHETISTS

SEC. 307. Section 831(b) (42 U.S.C. 297-1(b)) is amended by inserting after "1980" the following: ", $2,000,000 for the fiscal year ending September 30, 1981, $3,000,000 for the fiscal year ending September 30, 1982, and $4,000,000 for the fiscal year ending September 30, 1983".

STUDENT LOANS

SEC. 308. (a) Section 835(b)(4) (42 U.S.C. 297a(b)(4)) is amended by striking out "1980" and inserting in lieu thereof "1983".

(b)(1) Section 836(b)(1)(A) is amended by inserting after "(A)" the following: "is in exceptionally needy circumstances or is from a low-income or disadvantaged family (as those terms are defined by regulations under subsection (j)) and".

(2) The amendment made by paragraph (1) shall not apply with respect to any loan under subpart II of part B of title VIII of the Public Health Service Act to students who received such a loan before the date of the enactment of this Act.

(3) Section 836(b)(5) is amended by striking out "3" and inserting in lieu thereof "6".

(c) Section 837 (42 U.S.C. 297c) is amended (1) by striking out "and" after "1978,", (2) by inserting after "September 30, 1980" the following: ", $15,000,000 for the fiscal year ending September 30, 1981, $17,500,000 for the fiscal year ending September 30, 1982, and $20,000,000 for the fiscal year ending September 30, 1983", (3) by striking out "1981" in the second sentence and inserting in lieu thereof "1984", and (4) by striking out "October 1, 1980" and inserting in lieu thereof "October 1, 1983".

(d) Section 839 (42 U.S.C. 297e) is amended by striking out "1983" each place it occurs and inserting in lieu thereof "1986".

SCHOLARSHIPS

SEC. 309. Section 841 and subpart III of part B of title VIII are repealed.

TECHNICAL

SEC. 310. Section 851(a) (42 U.S.C. 298(a)) is amended by striking out ", and the Commissioner of Education, both of whom shall be ex officio members" and inserting in lieu thereof "and an ex officio member".

TITLE IV—GRADUATE MEDICAL EDUCATION NATIONAL ADVISORY COMMITTEE

GRADUATE MEDICAL EDUCATION NATIONAL ADVISORY COMMITTEE

SEC. 401. (a) Part A of title VII is amended by inserting after section 711 the following:

"GRADUATE MEDICAL EDUCATION NATIONAL ADVISORY COMMITTEE

"SEC. 712. (a)(1) There is established the Graduate Medical Education National Advisory Committee (hereinafter in this section referred to as the 'Advisory Committee'). The Advisory Committee shall consist of 23 members as follows:

"(A) A representative of the Public Health Service and a representative of the Health Care Financing Administration each designated by the Secretary, a representative of the Department of Defense designated by the Secretary of Defense, a representative of the Veterans' Administration designated by the Administrator of the Veterans' Affairs, and the Chairman of the Coordinating Council on Medical Education shall each be ex officio members of the Advisory Committee.

"(B) The Secretary shall appoint 18 members from individuals who are representative of providers of health care, insurers and other payers of health care, and interested national and local organizations.

"(2)(A) Except as provided in subparagraph (B), the term of office of a member of the Advisory Committee shall be three years.

"(B) Of the members first appointed to the Advisory Committee after the date of the enactment of this section—

"(i) six members shall be appointed to serve for terms of one year, and

"(ii) six members shall be appointed to serve for terms of two years,

as designated by the Secretary at the time of appointment. Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of such term. A member may serve after the expiration of the member's term until a successor has taken office.

"(3) Members of the Advisory Committee who are officers or employees of the United States shall serve without pay. The other members of the Advisory Committee shall be entitled to receive the daily equivalent of the annual rate of basic pay in effect for grade GS–18 of the General Schedule for each day (including traveltime) during which they are engaged in the actual performance of the duties vested in the Commission.

"(4) The Chairperson of the Advisory Committee shall be designated by the Secretary from the appointed members of the Advisory Committee.

"(5) The Advisory Committee shall meet at the call of the Chairperson, except that the Advisory Committee shall meet at least once every calendar quarter. Notice of meetings of the Advisory Committee shall be made available to the public and such meetings shall be open to the public.

"(6) The Secretary shall provide the Advisory Committee such support staff and administrative services as may be necessary for the Advisory Committee to carry out its functions under subsection (b).

"(b) The Advisory Committee shall—

"(1) advise, consult with, and make recommendations to, the Secretary with respect to—

"(A) the need for and supply of physicians in the various medical specialties (including subspecialties) and with respect to the geographic distribution of physicians;

"(B) the factors which affect a physician's choice of graduate medical training and the location of the physician's practice;

"(C) the effect that—

"(i) the rate of reimbursement for health care services provided by physicians in the different medical specialties, and

"(ii) the availability of financial support for persons undergoing graduate medical education.

has on the selection of a medical specialty or subspecialty;

"(D) the proportion of health services provided by persons undergoing graduate medical education; and

"(E) such other matters relating to graduate medical education as the Secretary may specify.

"(2) recommend to the Secretary goals for (A) the distribution of physicians by medical specialties and subspecialties, and (B) the number of graduate medical education positions that should be available in each of the medical specialties and subspecialties; and

"(3) recommend to the Secretary policies and procedures to achieve such goals.

The Advisory Committee shall inform the Secretary of the data it will need to carry out its functions under this subsection.

"(c)(1) The Advisory Committee shall consult with appropriate entities, including the Coordinating Council on

Medical Education and its constituent members, concerning appropriate actions to attain the goals recommended under subsection (b)(2).

"(2) The Secretary may enter into contracts with public and other nonprofit entities, including the Coordinating Council on Medical Education and its constituent members, to provide assistance to the Advisory Committee in carrying out its functions under subsection (b).

"(d) The Advisory Committee shall consult with the Health Care Financing Administration and private health insurance carriers concerning the changes in the rates of reimbursements for health services provided by physicians in graduate medical education training programs and other practicing physicians necessary to provide incentives to achieve the goals recommended by the Advisory Committee for the distribution of physicians by medical specialties.

"(e) The Advisory Committee shall submit to the Secretary an annual report respecting the activities of the Advisory Committee. The Advisory Committee shall include in such report a description of the consultations undertaken under subsection (c).".

(b) A member of the Graduate Medical Education National Advisory Committee established by the Secretary of Health, Education, and Welfare on May 1, 1978, shall continue in office as a member of the Advisory Committee established under subsection (a) for the term of office prescribed for that member.

TITLE V—MEDICARE AND MEDICAID AMENDMENTS RELATING TO PRIMARY CARE RESIDENCY PROGRAMS

OPTIONAL MEDICARE REIMBURSEMENT OF PRIMARY CARE RESIDENTS' SERVICES ON A CHARGE BASIS

SEC. 501. Section 1832 of the Social Security Act is amended—

(1) by inserting "(except as provided in subsection (b))" in subsection (a)(2)(B)(i)(I) after "a resident";

(2) by redesignating subsection (b) as subsection (c); and

(3) by inserting after subsection (a) the following new subsection:

"(b) At the election of a hospital, physicians' services furnished to outpatients of the hospital by a licensed physician who is a resident in an accredited residency program in the hospital in family medicine, primary internal medicine, or primary pediatrics (as defined by the Secretary in regulations) shall be treated, for purposes of this part, as services described in subsection (a)(1) and not as services described in subsection (a)(2)(B)(i)(I), and the reasonable costs of such a hospital shall not include (for purposes of section 1861(v)) costs which are determined to be properly allocable to the furnishing of such services.".

OPTIONAL MEDICARE AND MEDICAID REIMBURSEMENT OF PRIMARY CARE RESIDENTS' SERVICES ON A COST-RELATED BASIS

SEC. 502. (a)(1) Section 1832(a) of the Social Security Act is amended—

(A) by striking out "subparagraphs (B) and (D)" in paragraph (1) and inserting in lieu thereof "subparagraphs (B), (D), and (E)";

(B) by inserting "(except to the extent provided under subparagraph (E))" in paragraph (2)(B)(i)(I) after "a resident";

(C) by striking out "and" at the end of subparagraph (C) of paragraph (2);

(D) by striking out the period at the end of subparagraph (D) of paragraph (2) and inserting in lieu thereof "; and"; and

(E) by adding at the end the following new subparagraph:

"(E) at the election of the facility, primary care residency training facility services (as defined in section 1861(bb)(2)).".

(2) Section 1833(a) of such Act is amended—

(A) by striking out "subparagraph (D)" in paragraph (2) and inserting in lieu thereof "subparagraphs (D) and (E)";

(B) by striking out the period at the end of paragraph (3) and inserting in lieu thereof "; and"; and

(C) by adding after paragraph (3) the following new paragraph:

"(4) in the case of services described in section 1832(a)(2)(E), 80 percent of costs (including educational and supervisory physicians' costs) which are reasonable and related to the cost of furnishing such services or on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A).".

(3) Section 1861 of such Act is amended by adding at the end thereof the following new subsection:

"Primary Care Residency Training Facility Services

"(bb)(1) The term 'primary care residency training facility services' means physicians' services and such services and supplies as are covered under subsection (s)(2)(A) if furnished as an incident to a physician's professional service, when furnished to an individual as an outpatient of a primary care residency training facility.

"(2) The term 'primary care residency training facility' means a facility which—

"(A) is primarily engaged (i) in furnishing to outpatients physicians' services (and other services described in paragraph (1)), and (ii) in operating an approved residency training program in family medicine, primary internal medicine, or primary pediatrics (as determined by the Secretary in regulations);

"(B) has filed an agreement with the Secretary by which it agrees not to charge any individual or other person for items or services for which the individual is entitled to have payment made under this title, except for the amount of any deductible or coinsurance amount imposed with respect to such items or services (not in excess of the amount customarily charged for such items and services by such facility), pursuant to subsections (a) and (b) of section 1833; and

"(C) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are furnished services by the facility.".

(4) The amendments made by this subsection shall apply to services furnished on or after the first day of the third month which begins after the date of the enactment of this Act.

(b)(1) Section 1905(a)(2) of such Act is amended (A) by striking out "and" before "(B)", and (B) by inserting ", and

(C) primary care residency training facility services (as defined in section 1861(bb)(1))" before the semicolon at the end thereof.

(2) Section 1902(a) of such Act is amended by inserting "and" after the semicolon at the end of paragraph (13) and by adding at the end of such paragraph the following new subparagraph:

"(G) for payment for primary care residency training facility services (as defined in section 1861(bb)(1)) of 100 percent of costs (including educational and supervisory physician costs) which are reasonable and related to the cost of furnishing such services or based on such other tests of reasonableness as the Secretary may prescribe in regulations under section 1833(a)(4);".

(3)(A) The amendments made by this subsection shall (except as otherwise provided in subparagraph (B)) apply to medical assistance provided, under a State plan approved under title XIX of the Social Security Act, on or after the first day of the first calendar quarter that begins more than six months after the date of the enactment of this Act.

(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this subsection, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

TITLE VI—ALIEN GRADUATES OF FOREIGN MEDICAL SCHOOLS

ALIEN GRADUATES OF FOREIGN MEDICAL SCHOOLS

SEC. 601. (a) Section 212 of the Immigration and Nationality Act is amended by striking out the semicolon at the end of paragraph (32) of subsection (a) and inserting in lieu thereof a period and the following: "For the purpose of this paragraph and subsection (j)(1), an alien who is a graduate of a medical school shall be considered to have passed parts I and II of the National Board of Medical Examiners Examination if the alien was fully and permanently licensed to practice medicine in a State on January 9, 1977, and was practicing medicine in a State on that date;".

(b) Subsection (j) of such section is amended—

(1) by striking out "(including any extension of the duration thereof under subparagraph (D))" in paragraph (1)(C);

(2) by striking out "Secretary of Health, Education, and Welfare" in paragraph (1)(C) and inserting in lieu thereof "Secretary of Health and Human Services";

(3) by amending subparagraph (D) of paragraph (1) to read as follows:

"(D) The duration of the alien's participation in the program of graduate medical education or training for which the alien is coming to the United States is limited to the lesser of seven years or the time typically required to complete such program, as determined by the Director of the International Communication Agency at the time of the alien's entry into the United States, based on criteria established in coordination with the Secretary of Health and Human Services; except that the alien may, once and not later than two years after the date the alien enters the United States as an exchange visitor or acquires exchange visitor status, change the alien's designated program of graduate medical education or training if the Director approves the change and if a commitment and written assurance with respect to the alien's new program have been provided in accordance with subparagraph (C)."; and

(4) by striking out "December 31, 1980" in paragraph (2)(A) and inserting in lieu thereof "December 31, 1983".

(c)(1) The amendments made by paragraphs (1) and (2) of subsection (b) shall apply to aliens entering the United States as exchange visitors (or otherwise acquiring exchange visitor status) on or after January 10, 1978.

(2) Section 602 of the Health Professions Educational Assistance Act of 1976 (Public Law 94–484), added by section 307(q)(3) of Public Law 95–83, is amended by striking out subsections (a) and (b).

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96TH CONGRESS
2D SESSION

H. R. 6800

To amend provisions of law concerned with health professions education.

IN THE HOUSE OF REPRESENTATIVES

MARCH 12, 1980

Mr. STAGGERS (by request) introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

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A BILL

To amend provisions of law concerned with health professions education.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE AND REFERENCES IN ACT

SECTION 1. (a) This Act may be cited as the "Health Professions Education Amendments of 1980".

(b) Whenever in this Act an amendment is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act, unless otherwise specifically stated.

REPEAL OF CAPITATION AUTHORITIES

SEC. 2. (a)(1) Paragraph (2) of section 770(c) is amended—

(A) in the first sentence, by striking out "For purposes of this section, the" and inserting instead "The", and

(B) in the last sentence, by striking out "and for purposes of section 771, students enrolled in the first of the last four years of such program shall be considered as first-year students".

(2) That paragraph is renumbered as paragraph (11) and is transferred to the end of section 701.

(b)(1) Subsection (b) of section 772 is amended—

(A) by striking out "section 770 or subsection (a) or (b) of section 788" and inserting instead "subsection (b)", and

(B) by inserting "nursing," after "pharmacy,".

(2) That subsection is redesignated as subsection (h) and is transferred to the end of section 788.

(c) Part E of title VII is repealed.

(d) Subpart II of part A of title VIII is repealed.

REPEAL OF CONSTRUCTION AUTHORITIES

SEC. 3. (a) Section 722 is amended to read as follows:

"PAYMENTS

"SEC. 722. The Secretary shall reserve, from any appropriation available for a grant for a construction project under this part, the amount of such grant; the amount so reserved may be paid in advance or by way of reimbursement, and in such installments consistent with construction progress, as the Secretary may determine. The Secretary's reservation of any amount under this section may be amended by him, either upon approval of an amendment of the application or upon revision of the estimated cost of construction of the facility.".

(b) Section 803 is amended to read as follows:

"PAYMENTS

"SEC. 803. The Secretary shall reserve, from any appropriation available for a grant for a construction project under this subpart, the amount of such grant; the amount so reserved may be paid in advance or by way of reimbursement, and in such installments consistent with construction progress, as the Secretary may determine. The Secretary's reservation of any amount under this section may be amended by him, either upon approval of an amendment of the application or upon revision of the estimated cost of construction of the facility.".

(c) Section 723 is amended—

(1) by inserting "former" before "section 720(a)(1)" and "section 720(a)(2)",

(2) by striking out "section 722" and inserting instead "former section 722(d)",

(3) in subsection (a)(2), by inserting "(including the lack of further need for the teaching, research, or other capacity)" after "good cause", and

(4) in subsection (b)(2), by inserting "(including the lack of further need for the training capacity)" after "good cause".

(d) Section 804 is amended by inserting "(including the lack of further need for the training capacity)" after "good cause".

(e) Section 724 is amended to read as follows:

"REGULATIONS

"SEC. 724. The Secretary may make such regulations as he finds necessary to carry out the provisions of this part.".

(f) Sections 720, 721, 725, 801, and 802, subsections (a), (b), (c), and (f) of section 726, and subsections (a), (b), (c), and (f) of section 805 are repealed.

REPEAL OF STARTUP ASSISTANCE AUTHORITY

SEC. 4. Section 788(a) is repealed.

CONSOLIDATION AND EXTENSION OF FINANCIAL DISTRESS AUTHORIZATIONS

SEC. 5. (a) Paragraphs (1) and (3) of section 788(b) are each amended by inserting "nursing" after "podiatry," each place it occurs.

(b) Section 788(b) is amended by adding at the end the following paragraphs:

"(6) No school may receive a grant or contract under this subsection unless—

"(A) the school has submitted to the Secretary a plan to address the financial and management problems leading to the need for the grant or contract and has agreed to carry out that plan, and

"(B) the Secretary determines that the plan has a reasonable likelihood of success.

"(7) There are authorized to be appropriated to carry out the provisions of this subsection $9,200,000 for fiscal year 1981, and such sums as may be necessary for the two succeeding fiscal years.".

(c) Subpart III of part A of title VIII is repealed.

(d) Section 701 is amended by adding at the end the following paragraph:

"(12) The term 'school of nursing' has the meaning assigned by section 853(2).".

EXTENSION OF WAIVER OF SPECIAL REQUIREMENTS FOR MEDICAL EXCHANGE VISITORS TO PREVENT SUBSTANTIAL DISRUPTION IN HEALTH SERVICES

SEC. 6. Section 212(j)(2)(A) of the Immigration and Nationality Act is amended by striking out "1980" and inserting instead "1983".

EXTENSION AND REVISION OF PRIMARY CARE SUPPORT PROVISIONS

SEC. 7. (a) Section 780 is amended—

(1) by striking out "and" after "1979," and

(2) by inserting "$15,000,000 for the fiscal year ending September 30, 1981, and such sums as may be necessary for the two succeeding fiscal years," after "1980".

(b) Section 784 is amended to read as follows:

"GENERAL INTERNAL MEDICINE AND GENERAL PEDIATRICS

"SEC. 784. (a) The Secretary may make grants to, or enter into contracts with, any public or nonprofit private hospital, school of medicine or osteopathy, or to or with a public or private nonprofit entity (which the Secretary has determined is capable of carrying out such grant or contract)—

"(1) to plan, develop, and operate, or participate in, an approved professional training program (including a continuing education program or an approved residency or internship program) in the field of general internal medicine or general pediatrics for medical and osteopathic students, interns (including interns in internships in osteopathic medicine), residents, or practicing physicians;

"(2) to provide financial assistance (in the form of traineeships and fellowships) to medical and osteopathic students, interns (including interns in internships in osteopathic medicine), residents, or practicing physicians, who are in need thereof, who are participants in any such program, and who, if interns or residents, plan to specialize or work in the practice of general internal medicine or general pediatrics;

"(3) to plan, develop, and operate a program for the training of physicians who plan to teach in general internal medicine or general pediatrics training programs; or

"(4) to provide financial assistance (in the form of traineeships and fellowships) to physicians who are participants in any such program and who plan to teach in a general internal medicine or general pediatrics training program.

"(b) There are authorized to be appropriated for grants and contracts under this section $22,235,000 for fiscal year

1981 and such sums as may be necessary for the two succeeding fiscal years.".

(c)(1) Section 786(a) is amended—

(A) in paragraph (2), (i) by striking out "practicing physicians, or other medical personnel" and inserting instead "or practicing physicians", and (ii) by inserting ", if interns or residents," after "and who", and

(B) in paragraph (3), by striking out "and" after the semicolon and inserting instead "or".

(2) Subsections (b) and (c) of section 786 are repealed.

(3) Section 786(d) is amended—

(A) by striking out "to make grants" and inserting instead "for grants and contracts",

(B) by striking out "and" after "1979,", and

(C) by inserting ", $46,000,000 for the fiscal year ending September 30, 1981, and such sums as may be necessary for the two succeeding fiscal years" after "1980".

(4) The heading to section 786 is amended by striking out "AND GENERAL PRACTICE OF DENTISTRY".

EXTENSION AND REVISION OF NURSE PRACTITIONER AND PHYSICIAN ASSISTANT AUTHORITIES

SEC. 8. (a) Section 822 is amended to read as follows:

"NURSE PRACTITIONER PROGRAMS

"SEC. 822. (a) The Secretary may make grants to and enter into contracts with public or private schools of nursing, medicine, or public health, public or nonprofit private hospitals, and other public or nonprofit entities to establish and operate traineeship programs to train nurse practitioners which give special consideration to individuals who are residents of a health manpower shortage area (designated under section 322).

"(b) No grant or contract may be made under subsection (a) unless the application therefor contains or is supported by assurances satisfactory to the Secretary that the school or entity receiving the grant or contract has appropriate mechanisms for placing graduates of the training program with respect to which the application is submitted, in positions for which they have been trained.

"(c)(1) A traineeship funded under this section shall not be awarded unless the recipient enters into a commitment, as prescribed by the Secretary, to practice as a nurse practitioner in a health manpower shortage area (designated under section 332).

"(2) If an individual breaches his commitment under paragraph (1) by failing (for any reason) either to begin such individual's commitment or to complete such commitment, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula

$$A=3\phi\left[\frac{t-s}{t}\right]$$

in which 'A' is the amount the United States is entitled to recover; 'ϕ' is the sum of the amounts paid under this subsection to or on behalf of the individual and the interests on such amounts which would be payable if at the time the amounts were paid they were loans bearing interest at the private consumer rates of interest, as determined by the Secretary of the Treasury; 't' is the total number of months in the individual's commitment period; and 's' is the number of months of such period served by him. Any amount of damages which the United States is entitled to recover under this paragraph shall, within the one-year period beginning on the date of the breach of the commitment, be paid to the United States.

"(3)(A) Any obligation of an individual under this subsection for service or payment of damages shall be canceled upon the death of the individual.

"(B) The Secretary shall by regulation provide for the waiver or suspension of any obligation of service or payment by an individual under this subsection whenever compliance by the individual is impossible or would involve extreme hardship to the individual and if enforcement of such obligation with respect to any individual would be unconscionable.

"(C) Any obligation of an individual under this subsection for payment of damages may be released by a discharge in bankruptcy under title II of the United States Code only if such discharge is granted after the expiration of the five-year period beginning on the first date that payment of such damages is required.

"(d) The costs for which a grant or contract under this section may be made include costs of preparing faculty members to teach in programs for the training of nurse practitioners.

"(e) For payments under grants and contracts under this section there are authorized to be appropriated $18,000,000 for fiscal year 1981 and such sums as may be necessary for the two succeeding fiscal years.".

(b) Section 782 is amended to read as follows:

"PHYSICIAN ASSISTANT PROGRAMS

"SEC. 782. (a) The Secretary may make grants to and enter into contracts with public or nonprofit private schools of medicine or osteopathy and other public or nonprofit private entities to establish and operate traineeship programs to train physician assistants which give special consideration to individuals who are residents of a health manpower shortage area (designated under section 332).

"(b) No grant or contract may be made under subsection (a) unless the application therefor contains or is supported by assurances satisfactory to the Secretary that the school or entity receiving the grant or contract has appropriate mechanisms for placing graduates of the training program with respect to which the application is submitted, in positions for which they have been trained.

"(c)(1) A traineeship funded under this section shall not be awarded unless the recipient enters into a commitment, as prescribed by the Secretary, to practice as a physician assistant in a health manpower shortage area (designated under section 332).

"(2) If an individual breaches his commitment under paragraph (2) by failing (for any reason) either to begin such individual's commitment or to complete such commitment, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula

$$A=3\phi\left[\frac{t-s}{t}\right]$$

in which 'A' is the amount the United States is entitled to recover; 'ϕ' is the sum of the amounts paid under this subsection to or on behalf of the individual and the interest on such amounts which would be payable if at the time the amounts were paid they were loans bearing interest at the private consumer rates of interest, as determined by the Secretary of the Treasury; 't' is the total number of months in the individual's commitment period; and 's' is the number of months of such period served by him. Any amount of damages which the United States is entitled to recover under this paragraph shall, within the one year period beginning on the date of the breach of the commitment, be paid to the United States.

"(3)(A) Any obligation of an individual under this subsection for service or payment of damages shall be canceled upon the death of the individual.

"(B) The Secretary shall by regulation provide for the waiver or suspension of any obligation of service or payment by an individual under this subsection whenever compliance by the individual is impossible or would involve extreme hardship to the individual and if enforcement of such obligation with respect to any individual would be unconscionable.

"(C) Any obligation of an individual under this subsection for payment of damages may be released by a discharge in bankruptcy under title II of the United States Code only if such discharge is granted after the expiration of the five-year period beginning on the first date that payment of such damages is required.

"(d) The costs for which a grant or contract under this section may be made include costs of preparing faculty members to teach in programs for the training of physician assistants.

"(e) For payments under grants and contracts under this section there are authorized to be appropriated $7,500,000 for fiscal year 1981 and such sums as may be necessary for the two succeeding fiscal years.".

EXTENSION OF AUTHORIZATIONS FOR DENTAL TEAM PRACTICE PROGRAMS

SEC. 9. (a) Section 783(a) is amended to read as follows:

"SEC. 783. (a) The Secretary may make grants to and enter into contracts with public or nonprofit private schools of dentistry and other public or nonprofit private entities to meet the costs of projects to plan, develop, and operate or maintain a program to train dental students in the organization and management of multiple auxiliary dental team practice in accordance with regulations of the Secretary.".

(b) Subsections (c) and (d) of section 783 are repealed.

(c) Section 783(e) is amended—

(1) by striking out "and" after "1979,", and

(2) by inserting ", $2,000,000 for the fiscal year ending September 30, 1981, and such sums as may be necessary for the two succeeding fiscal years" after "1980".

(d) The heading to section 783 is amended by striking out "PHYSICIAN ASSISTANTS, EXPANDED FUNCTION DENTAL AUXILIARIES AND".

REVISION AND EXTENSION OF THE NATIONAL HEALTH SERVICE CORPS AND NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP PROGRAM AUTHORITIES

SEC. 10. (a) Section 756 is amended—

(1) by striking out subsection (b), and

(2) by striking out the subsection designation "(a)".

(b) Section 753(a) is amended—

(1) in the matter preceding paragraph (1), by inserting "(and may release an individual from all or part of his service obligation under former section 225)" after "section 752(a)",

(2) in paragraph (2), by striking out (A) the clause designation "(A)", and (B) everything after "section 333(c)," but before the period, and

(3) by striking out the second sentence.

(c) Section 755(a)(1) is amended by striking out "his period of obligated service" and inserting instead "a period of at least two-years service".

(d) Section 751(d) is amended to read as follows:

"(d) In determining which applications under the Scholarship Program to approve (and which contracts to accept), the Secretary shall give priority to applications made (and contracts submitted) by individuals who have previously received scholarships under the Scholarship Program or under section 758.".

(e) Section 331(f) is amended by striking out "Sections 214 and 216" and inserting instead "Section 214".

(f) Subpart IV of part C of title VII is amended by adding at the end the following section:

"COOPERATIVE AGREEMENTS WITH STATES

"SEC. 757A. The Secretary may enter into cooperative agreements with States under which—

"(1) a State shall develop a plan for reducing geographic maldistribution of health professionals in the State, utilizing a State health professionals placement program as well as the Corps, and

"(2) the Secretary, upon approval of the plan, shall arrange for appropriate assignment of Corps personnel to the State consistent with the plan and with available Federal resources.

The Secretary shall give priority under this section to States that provide substantial State financial support for health professionals placement programs designed to reduce geographic maldistribution.".

(g)(1) The first sentence of section 756 is amended—

(A) by striking out "and" after "1979,", and

(B) by inserting ", $93,500,000 for the fiscal year ending September 30, 1981, and such sums as may be necessary for the two succeeding fiscal years" after "1980".

(2) The second sentence of that section is amended by striking out "1981" and "1980" and inserting instead "1984" and "1983", respectively.

(h) Section 338 is amended—

(1) by striking out "and" after "1979;", and

(2) by inserting "; $132,696,000 for the fiscal year ending September 30, 1981; and such sums as may be necessary for the two succeeding fiscal years" after "1980".

EXTENSION OF AREA HEALTH EDUCATION CENTERS AUTHORIZATIONS

SEC. 11. Section 781(g) is amended—

(1) by striking out "and" after "1979,", and

(2) by adding ", $21,000,000 for the fiscal year ending September 30, 1981, and such sums as may be necessary for the two succeeding fiscal years" after "1980".

EXTENSION OF AUTHORIZATIONS FOR THE SCHOLARSHIP AND EDUCATIONAL ASSISTANCE PROGRAMS FOR THE DISADVANTAGED

SEC. 12. (a)(1) Section 758(c) is amended to read as follows:

"(c) The Secretary shall give special consideration in making grants under this section to schools of medicine, osteopathy, and dentistry.".

(2) Section 758(d) is amended—

(A) by striking out "and" after "1979,", and

(B) by inserting ", $10,000,000 for the fiscal year ending September 30, 1981, and such sums as may be necessary for the two succeeding fiscal years" after "1980".

(b)(1) Section 787(a)(1) is amended—

(A) by striking out "and enter into contracts with",

(B) by inserting ", and may enter into contracts with public and private entities," after "educational entities", and

(C) by adding at the end "The Secretary may provide funding under this section for stipends.".

(2) Section 787(b) is amended—

(A) by striking out "and" after "1979,", and

(B) by inserting "$22,392,000 for the fiscal year ending September 30, 1981, and such sums as may be necessary for the two succeeding fiscal years" after "1980,".

REVISION AND EXTENSION OF SPECIAL PROJECTS AUTHORITIES

SEC. 13. (a)(1) Section 788(d) is amended—

(A) by striking out "and enter into contracts with", and

(B) by inserting ", and may enter into contracts with any public or private entity," after "nonprofit private entity".

(2) Section 788(d) is further amended by striking out "such as" and all that follows and inserting instead the following: "(including, but not limited to, projects for public health and health administration training). An applicant for a grant or contract under this subsection shall demonstrate, where appropriate, that the project will be integrated into the core curriculum of the applicant's training program, and shall agree to provide a timetable and criteria for evaluating the success of the project in terms of meeting defined objectives. The Secretary may provide funding under this subsection for stipends.".

(3) Section 788(e) is amended to read as follows:

"(e) There are authorized to be appropriated to carry out the provisions of subsection (d) $17,000,000 for fiscal year 1981 and such sums as may be necessary for the two succeeding fiscal years.".

(b)(1) Section 820(a) is amended by striking out paragraphs (1) through (8) and inserting instead the following:

"(1) improve the geographic distribution of nurses, with a focus on areas with low-income populations,

"(2) increase nursing education opportunities for individuals from disadvantaged backgrounds,

"(3) develop innovative nursing methods emphasizing primary care and prevention to help meet the needs of high-risk groups, especially the elderly, children, and pregnant women,

"(4) provide training (such as continuing education and advanced nurse training) to enhance clinical skills, with an emphasis on primary care and the needs of high-risk groups, or

"(5) carry out other activities related to nurse training.

An applicant for a grant or contract under this section shall demonstrate, where appropriate, that the project will be integrated into the core curriculm of the applicant's teaching program, and shall agree to provide a timetable and criteria for evaluating the success of the project in terms of meeting defined objectives. The Secretary may provide funding under this section for stipends.".

(2) Section 820(d) is amended—

(A) by striking out "and" after "1978,", and

(B) by inserting ", $9,600,000 for the fiscal year ending September 30, 1981, and such sums as may be necessary for the two succeeding fiscal years" after "1980".

ABOLITION OF THE NATIONAL ADVISORY COUNCIL ON NURSE TRAINING

SEC. 14. (a) Section 851 is repealed.

(b)(1) The first sentence of section 702(a) is amended—

(A) by striking out "parts B, C, D, E, F, and G of", and

(B) by inserting "and title VIII" before the period.

(2) The second sentence of section 702(a) is amended—

(A) by inserting "or title VIII" after "this title", and

(B) by striking out "and public health, and entities which may receive a grant under section 791" and inserting instead "nursing, and public health".

(3) Subsections (b) and (c) of section 702 are each amended by striking out "(other than subpart II of part G thereof)" and inserting instead "and title VIII".

ELIMINATION OF UNNECESSARY REPORTING REQUIREMENTS

SEC. 15. Section 951 of the Nurse Training Act of 1975, and sections 336 and 751(i) are repealed.

AMENDMENTS TO HEALTH EDUCATION ASSISTANCE AND NURSING STUDENT LOANS PROVISIONS

SEC. 16. (a) The heading to subpart I of part C of title VII is amended to read as follows:

"Subpart I—Health Education Assistance Loans".

(b)(1) The second sentence of section 728(a) is amended—

(A) by striking out "Thereafter" and inserting instead "After September 30, 1983", and

(B) by striking out "September 30, 1982" and inserting instead "September 30, 1985".

(2) Section 728(a) is amended by adding at the end the following sentence: "Commitments to insure loans under this subpart are authorized for any fiscal year only to the extent or in such amounts as are provided in an appropriation Act.".

(c) Section 729(a) is amended—

(1) in the first sentence, by striking out everything after "$10,000" through "school of pharmacy", and

(2) in the second sentence, by striking out everything after "$50,000" through "school of pharmacy".

(d)(1) The first sentence of section 701(11) is amended by inserting ", or to a degree, diploma, or equivalent in nursing" before the period.

(2) Section 737(1) is amended by inserting "nursing," after "veterinary medicine,".

(e) Section 731(a)(1)(A) is amended—

(1) by adding "and" at the end of clause (iv),

(2) by striking out clause (v), and

(3) by renumbering clause (vi) as (v).

(f) Subparagraphs (B) and (C)(ii) of section 731(a)(2) are each amended by striking out "accredited" and inserting instead "approved".

(g) Section 731(a)(2)(B) is amended by striking out "(ii) that the period of the loan may not exceed 23 years from the date of execution of the note or written agreement evidencing it, and (iii)" and inserting instead "and (ii)".

(h)(1) Section 731(b) is repealed.

(2) Section 731(a)(2)(D) is amended by striking out "(within the limits set forth in subsection (b))".

(i) Section 731 is amended by adding at the end the following subsection:

"(e) The Secretary may not insure under the provisions of this subpart a loan made to an individual who is in default on a loan made under this subpart or under part B of title IV of the Higher Education Act of 1965.".

(j) Section 835(b)(4) is amended by striking out ", and that while the agreement remains in effect no such student who has attended such school before October 1, 1980, shall receive a loan from a loan fund established under section 204 of the National Defense Education Act of 1958".

MODIFICATIONS TO HEALTH PROFESSIONS DATA PROVISIONS

SEC. 17. (a) Section 708(b) is amended by striking out paragraphs (1) and (3) and the paragraph designation "(2)".

(b) Section 708(f) is repealed.

REPEAL OF OBSOLETE AND UNNEEDED PROVISIONS

SEC. 18. Section 700, subpart III of part C of title VII, section 759, part D of title VII, section 785, subsections (c), (f), and (g) of section 788, section 789, part G of title VII, section 821, subpart I of part B of title VIII, section 841, and subpart III of part B of title VIII are repealed.

TECHNICAL AND CONFORMING AMENDMENTS

SEC. 19. (a) Section 331(g) is repealed.

(b)(1) Section 701 is amended—

(A) in paragraph (3), by striking out "which meets the eligibility conditions set forth in section 721(b)(1)",

(B) by striking out paragraphs (5), (7), and (9), and

(C) in paragraph (10), by striking out ", Education, and Welfare" and inserting instead "and Human Services".

(2) Section (2)(f) is amended by striking out "701(9),".

(c) Section 703 is amended—

(1) by striking out subsection (b), and

(2) by striking out the subsection designation "(a)".

(d) The first sentence of section 704 is amended by inserting "nursing," after "podiatry,".

(e) Section 708(c) is amended—

(1) by striking out the first sentence, and

(2) by striking out "additional" in the second sentence.

(f) Section 710 is amended by striking out "except for grants under section 770".

(g) Section 731(a)(1)(A)(ii) is amended by striking out "(as defined in section 770(c)(2))".

(h) Section 735(c)(1) is amended by striking out "clauses (A) and (B) of".

(i) The first sentence of sections 735(c)(2) and 754(c) are each amended—

(1) by striking out "maximum legal prevailing rate" and inserting instead "private consumer rates of interest", and

(2) by striking out "Treasurer of the United States" and inserting instead "Secretary of the Treasury".

(j) Section 737(1) is amended by striking out everything after "United States" and inserting instead a period.

(k) The heading to section 788 is amended to read as follows:

"PROJECT GRANT AUTHORITY FOR FINANCIAL DISTRESS AND SPECIAL PROJECTS".

(l) Subsections (b) and (c) of section 820 and section 856(1) are each amended by striking out "Nurse Training" and inserting instead "Health Professions Education".

(m) Section 853 is amended by striking out paragraph (1).

EFFECTIVE DATES

SEC. 19. (a) The amendments enacted by section 16 of this Act are effective with respect to loans made after the date of enactment of this Act.

(b) The amendments enacted by this Act (other than by section 16) are effective as of the date of enactment of this Act, except that they shall not apply with respect to funds appropriated for any fiscal year before fiscal year 1981.

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C. 20201

The Honorable Harley O. Staggers
Chairman, Committee on Interstate
and Foreign Commerce
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

This is in response to your request for a report on H.R. 6800, a bill "To amend provisions of law concerned with health professions education."

H.R. 6800 is the Administration's proposal concerned with health professions education. The Department transmitted the proposal as a draft bill on March 6 to the Speaker of the House. A copy of our transmittal letter is enclosed.

We urge that the Committee give H.R. 6800 its prompt and favorable consideration.

We are advised by the Office of Management and Budget that enactment of H.R. 6800 would be in accord with the program of the President.

Sincerely yours,

Patricia Roberts Harris
Patricia Roberts Harris

Enclosure

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C. 20201

MAR 5 1980

The Honorable Thomas P. O'Neill
Speaker of the House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

Enclosed for consideration by the Congress is a draft bill "To amend provisions of law concerned with health professions education."

The draft bill would authorize appropriations of $426 million for fiscal year 1981, and "such sums as may be necessary" for fiscal years 1982 and 1983, for various health professions education authorities. A detailed summary of the draft bill is enclosed.

The primary objectives of the draft bill are to --

-- remove incentives for unwarranted growth in the aggregate supply of health professionals, especially physicians.

-- promote an increase in the supply of primary care health professionals, currently in short supply.

-- assure the availability of health professionals in medically underserved areas, largely by strengthening the role of the National Health Service Corps.

-- increase minority participation in the health professions.

-- target Federal resources to promote other national priorities, such as public health training, cost-containment and efficiency in delivery of health care services, and care for high-risk groups, such as the elderly, pregnant women, and children.

The health professions education assistance authorities of the last two decades focused primarily on stimulating increases in the aggregate supply of health care professionals. The nation's training capacity has been significantly expanded as a consequence. Current and projected aggregate supply of health professionals appears to be adequate to meet the requirements of our health care delivery system. However, there is a continued need to address the problems of geographic and specialty maldistribution.

This draft bill would serve as the vehicle to refine our Federal health professions education assistance efforts for promoting a balanced supply of health professionals to meet the health care needs of the American people.

First, termination of capitation grants, and elimination of general construction grants and start-up assistance, would remove incentives for unwarranted growth in the aggregate supply of health professionals. However, short-term financial distress assistance would continue to provide grants to institutions experiencing serious financial difficulties and requiring assistance for achieving fiscal stability and managerial reforms.

Second, continued targeted support for primary care physician training (family medicine, general internal medicine, and general pediatrics), nurse practitioner and physician assistant training, and training in dental team practice would promote increases in the supply of primary care health professionals.

Third, the expansion of the National Health Service Corps Program would increase the availability of much needed health professionals in health manpower shortage areas. The draft bill would also enact an authority for developing cooperative agreements with States to reduce geographic maldistribution of health professionals. In addition, the draft bill would permit continuation of the Health Professions Student Loan Repayment Program, which encourages individuals to practice in a health manpower shortage area in return for partial loan forgiveness. To complement these programs and those in primary care training, the draft bill would continue support for area health education centers, which provide remote site delivery of health care services and primary care training opportunities in underserved areas.

Fourth, continued support for the exceptional financial need scholarships program and the disadvantaged assistance program would promote increased training opportunities and participation of minorities and low-income individuals in the health professions. The disadvantaged assistance program would be targeted administratively to emphasize linkages between recruitment and enrichment programs, aimed at attracting disadvantaged students and increasing their enrollment in the health professions schools.

Fifth, special projects grants would target resources to complement initiatives in promoting a more balanced supply of health professionals, focusing on public health and primary care training, especially for high risk-groups, and promotion of cost-containment and efficiency in the management and delivery of health care services.

Sixth, the draft bill would extend for three more years the phase-in of the special immigration requirements for medical exchange visitors, so as to prevent substantial disruption in the health services provided by specific medical training programs.

We urge that the Congress give the draft bill its prompt and favorable consideration.

The Office of Management and Budget advises that enactment of the draft bill would be in accord with the program of the President.

Sincerely yours,

Patricia Roberts Harris

Enclosures

SUMMARY OF PROPOSED HEALTH PROFESSIONS EDUCATION AMENDMENTS OF 1980

I. Appropriation Authorizations

The draft bill would authorize the following appropriations (in millions of dollars):

	FY 1981	FY 1982	FY 1983
Financial distress	9.2		
Departments of family medicine	15		
General internal medicine and general pediatrics	22.235		
Family medicine	46		
Nurse practitioners	18		
Physician assistants	7.5		
Dental team practice programs	2	"such sums as may be necessary"	
National Health Service Corps Scholarship Program	93.5		
National Health Service Corps	132.696		
Area health education centers	21		
Scholarships for the disadvantaged	10		
Educational assistance for the disadvantaged	22.392		
Special Projects	17		
Nursing special projects	9.6		
	426.123		

II. Other Provisions

The draft bill would --

-- repeal the authorities for making capitation payments to various health professions schools (sec. 2).

-- repeal the authorities for health professions facilities construction grants, loan guarantees, and interest subsidies (but would not affect the authority of the Secretary of Health, Education, and Welfare to monitor the continued compliance with conditions associated with financial assistance previously received by health professions facilities, or to continue to pay interest subsidies with respect to loans previously made) (sec. 3).

-- repeal the start-up assistance authority (sec. 4).

-- consolidate the nursing and other health professions schools financial distress authorities (sec. 5).

-- permit waiver of the special immigration requirements for medical exchange visitors through calendar year 1983 to prevent the substantial disruption in the health services provided in a medical training program (sec. 6).

-- repeal the general dentistry training authority (sec. 7).

-- modify the authority for the support of nurse practitioner training programs by (1) permitting individuals who do not reside in a health manpower shortage area to receive a traineeship, but providing for special consideration for individuals who do reside in such an area, (2) eliminating the requirement that traineeship amounts must cover 100 percent of the recipient's costs, (3) clarifying the Secretary's authority to determine the service commitment required of each beneficiary, (4) specifying a triple payback penalty (with interest) if a beneficiary fails to carry out the commitment made, and (5) consolidating and simplifying current language (sec. 8).

-- conform the requirements for the support of physician assistant training programs to those (as modified by the draft bill) for the support of nurse practitioners (sec. 8).

-- eliminate the required set-asides under the National Health Service Corps Scholarship Program for medical, osteopathic, and dental students; make clear that the private practice option may be offered to individuals who received scholarships before October 1, 1977, and eliminate the requirement that the Secretary determine that each private practice location provides a "sufficient financial base" for the individual wishing to engage in private practice; permit special grants for entering private practice to be made to any former Corps member who served at least two years in the Corps, whether or not the former member had received a scholarship; eliminate the scholarship priority for first year students; and permit commissioned officers in the Corps to be subject to military law in wartime or in a national defense emergency (sec. 10).

-- authorize the Secretary to enter into cooperative agreements with States under which a State would develop a plan for reducing geographic maldistribution of health professionals in the State, utilizing a State health professionals placement program as well as the Corps, and under which the Secretary, upon approval of the plan, would arrange for appropriate assignment of Corps personnel to the State (sec. 10).

-- eliminate the requirement under the scholarship program for the disadvantaged that the Secretary must distribute the scholarship grants among all schools of the health professions (sec. 12).

-- permit the Secretary to enter into contracts with for-profit entities under the educational assistance for the disadvantaged program (sec. 12).

-- revise the special projects authority by eliminating the current list of twenty-one specific examples and by stating instead that projects may include, but are not limited to, projects for public health and health administration training. In addition, the Secretary could enter into contracts with for-profit entities (sec. 13).

-- revise the nursing special projects authority by eliminating the current list of eight kinds of projects and by stating instead that projects are to be for (1) improving the geographic distribution of nurses, (2) increasing nursing education opportunities for individuals from disadvantaged backgrounds, (3) developing innovative nursing methods emphasing primary care and prevention to help meet the needs of high risk groups, (4) providing training to enhance clinical skills, with an emphasis on primary care and the needs of high risk groups, or (5) carrying out other activities related to nurse training (sec. 13).

-- abolish the National Advisory Council on Nurse Training and assign its functions to the National Advisory Council on Health Professions Education (sec. 14).

-- eliminate a number of overlapping reporting requirements (sec. 15).

-- amend the provisions of law governing the Health Education Assistance Loans Program (HEAL) by (1) extending the authority of the Secretary to guarantee loans through fiscal year 1983, (2) increasing the annual borrowing limit for pharmacy students to $10,000, and the aggregate limit for such students to $50,000, (3) making nursing students eligible for loans, (4) repealing the 12 percent ceiling on the interest rate, and (5) making certain other relatively minor changes (sec. 16).

-- eliminate a restriction that prevents certain nursing students from applying for National Direct Student Loans (sec. 16).

-- repeal, in relation to health professions data, (1) a requirement that the Secretary collect available information from various sources, (2) a grant and contract authority for the States or other entities to collect data, and (3) a provision exempting data collection from review by the Office of Management and Budget (sec. 17).

-- repeal a number of remaining health professions education authorities (sec. 18).

Mr. WAXMAN. Today is the first of at least 4 days of hearing on this legislation. We are looking forward to discussing all of the important issues in this area with our many witnesses. Before I call upon our first witness I would like to call upon Dr. Carter for any opening statements.

Mr. CARTER. Thank you, Mr. Chairman. I am pleased to join you in holding this set of hearings over the next few days on legislation to reauthorize various health professions educational assistance programs.

Because the quality of health care which our citizens receive is so closely linked to the quality of training received by our Nation's health care providers, I believe that the Federal Government does have a responsibility to contribute to the support of these institutions. I have joined as a sponsor of H.R. 6802 because of its commitment to that principle.

Mr. Chairman, we all realize that these are troublesome times for our Nation and for the economy, and we all realize that difficult budgetary decisions will have to be made. I would urge as we review these health professions programs in this context, that we keep in mind the important national purposes which these programs serve and that we accord them appropriate priority in our reauthorizations.

In particular, I hope that we can look carefully at the best ways to address financial needs of health professions students as well as the needs of the institutions they attend. I also hope that we can provide the necessary assistance for our minority institutions, whose continued viability is essential to assuring access to health care for all Americans.

I trust, Mr. Chairman, that with the Federal aid which we have given over the years to the different medical schools in our country, there has been an increase in the knowledge and the skills of our graduates. However, sometimes I wonder, Mr. Chairman, since just now I asked a young doctor to name the bones in the wrist and he had difficulty doing so. Dr. Richmond, I am sure you would have no trouble naming those bones.

Dr. RICHMOND. I think I can still do it.

Mr. CARTER. You think you know them? Would you mind calling them out? There is an old saying with which you are probably familiar.

Dr. RICHMOND. Yes, I know the ditty.

Mr. CARTER. It isn't said really in polite society.

Dr. RICHMOND. Only among medical students.

Mr. CARTER. But, you know, it is amazing to me that a medical student today would not know the bones of the wrist. Thank you very kindly. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Dr. Carter. I think the witnesses have now some hint of questions yet to come. But before we get into questions, I would like to welcome Dr. Julius Richmond, the Assistant Secretary for Health and the Surgeon General of the Department of Health, Education, and Welfare.

Dr. Richmond is a former member of the faculty at Harvard and is well qualified to speak on manpower issues. Accompanying Dr. Richmond is Dr. Henry Foley, Dr. Edward Martin, and Mr. Thomas Hatch, who are responsible for the administration of the health manpower programs.

We welcome you today. You may proceed in any way you wish. Your complete statement will be made a part of the record in its entirety. If you summarize, that would be fine. If you read it, that too will be acceptable.

STATEMENT OF JULIUS B. RICHMOND, M.D., ASSISTANT SECRETARY FOR HEALTH AND SURGEON GENERAL, PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY HENRY A. FOLEY, PH. D., ADMINISTRATOR, HEALTH RESOURCES ADMINISTRATION; EDWARD D. MARTIN, M.D., DIRECTOR, BUREAU OF COMMUNITY HEALTH SERVICES, HEALTH SERVICES ADMINISTRATION; AND THOMAS HATCH, ACTING DIRECTOR, BUREAU OF HEALTH PROFESSIONS, HEALTH RESOURCES ADMINISTRATION

Dr. RICHMOND. Thank you, Mr. Chairman. I think you and Dr. Carter have already indicated the significance of the issues which we are considering today. I would like to present in some detail our policy for developing adequate health personnel resources for the Nation. We have seen a very remarkable record of achievement for the Nation.

You have already pointed out that we come before you at a time when uppermost in our minds is the common concern of the President and the Congress over inflation. An essential outgrowth of that concern, of course, is the need to consider some reduction in Federal spending.

I would point out and with significant emphasis that the bill which we recently submitted to the Congress to renew the authorities for health professions education calls for modest Federal activities in this field. We have deliberately chosen this modest role because we believe that it is the appropriate Federal posture. We did not adopt it initially merely because of the concern about Federal expenditures.

I would emphasize that this philosophy for the development of adequate resources leads us to some major elements in our bill. Simply stated, we are concerned with the identification of the major shortcomings in the Nation's health personnel resources, embracing the determination by the Federal Government to concentrate on those deficiencies and leaving to the operation of America's State and private educational systems, aided by supplementary Federal programs, the wide range of other activities needed to prepare health personnel.

I would observe that this approach continues the historical experience of the Federal Government in the health personnel field. Only in the last two decades of the Nation's 200-year history has major Federal legislation affecting health personnel training been enacted, and each of the series of statutes has been directed at specific national problems.

That is the approach in the legislation we are now proposing. This legislation represents our best thinking in this area. However, I want to emphasize our interest in continuing to review carefully other proposals developed by Members of Congress and our willingness to work with you in shaping this important legislation.

Today we identify three major imbalances in the personnel resources for the delivery of health care to the American people:

There are too few professionals trained in the provision of primary care.

There are too few personnel located in a significant number of rural and urban communities.

There are too few persons from minority backgrounds who enter the health professions.

Our bill provides for programs to deal with each of these deficiencies. In addition it provides authority to engage in special projects that focus on other problems of national importance. Later I will have some comments on provisions in the current act which, we believe, should not be renewed.

PRIMARY CARE PERSONNEL

As each individual and family attempts to engage in the health practices that prevent illness and to secure early medical care when they become ill, they need to rely on a primary care provider, the person who is their first and regular source of care.

This mode of service is the most effective and the most efficient for the consumer, for the practitioner and for the community. The adult looks to the family physician or the general internist, the child looks to the family physician or the general pediatrician, or the family first reaches the trained nurse practitioner or physician assistant.

Unfortunately the number of these primary care providers is inadequate; they do not represent a sufficiently large share of the total supply of physicians. Or, putting it another way, we are producing more specialists than we need in some fields at the expense of the primary care personnel we need.

In 1950 about half of all physicians practiced primary care. By 1977 the percentage in primary care had dropped to 39. Our best judgment is that we need to return to the 50-percent level. A study by the Institute of Medicine supports this conclusion.

I know that some studies have shown that specialists spend substantial amounts of their time providing primary care services. Although this may increase the basic medical care for some, we question whether it is the most appropriate or cost-effective means of providing primary care.

Basic primary care delivered by specialists is more expensive than that provided by generalists. Specialized internists charge 50 percent more than generalists for a periodic examination and for a followup office visit.

Generalists are specially trained to treat "the whole patient." Specialists' training is more hospital-oriented, relies more heavily on high technology and focuses on specific pathology.

We therefore believe that it is important to correct this imbalance of specialization.

In large part as a result of programs initiated under prior health professions legislative authority, some reversal of the trend has begun to occur. Today 41 percent of all residency positions offered are in primary care. The Institute of Medicine suggests that up to 60 or 70 percent may be required to achieve the balance we seek.

For these reasons, we recommend continuation of the authorities to fund programs in medical and osteopathic schools to establish and maintain departments of family medicine; to fund residency programs in family medicine, general internal medicine, and general pediatrics; to fund training for nurse practitioners and physician assistants; and to fund programs for dental team practice training.

In addition we recommend new authority to fund medical and osteopathic schools or hospitals to plan and operate special programs for training medical students, practicing physicians and faculty in general internal medicine and general pediatrics.

PERSONNEL FOR UNDERSERVED AREAS

One of the intractable problems in assuring adequate health care for the United States population is the inadequacy of personnel in many communities across the country. Geographic maldistribution is one of our basic health personnel problems.

We estimate that in 1990 up to 16,400 additional physicians and midlevel professionals could be needed in medically underserved areas and facilities—7,500 in rural areas, 5,200 in inner cities and 3,700 in prisons and mental institutions. These estimates assume that the number of physicians choosing to locate in rural areas increases because more are entering practice in the aggregate.

Fortunately there is evidence of some increase in the number of physicians moving into smaller cities and towns over the past 5 to 7 years. However, most of the increase in physician-population ratios has occurred in medium sized rural towns. Few of these physicians have chosen to locate in the most underserved areas—largely poor or highly rural communities with few health resources—designated as high priority by the Federal Government.

We are examining ways to improve this situation. We know that you yourself and members of the committee have expressed concern in this regard and we hope to work with the Congress in seeking solutions.

Between 1971 and 1977 the physician-population ratio increased from 48 physicians per 100,000 to 50 physicians per 100,000 in highly rural areas. This compares with an increase in the ratio from 72 physicians per 100,000 to 87 per 100,000 population in other rural areas and an increase in the ratio from 146 physicians per 100,000 to 168 in metropolitan areas. In high poverty areas the physician-population ratio increased modestly from 68 physicians per 100,000 to 74 physicians per 100,000 population.

In poor rural and urban counties, the problem is exacerbated because many physicians choose not to accept medicaid patients; 22 percent of primary care physicians have no medicaid patients.

There is also some expectation that the proportion as well as the numbers of physicians going to underserved areas will increase as the supply of doctors grows. Almost 14,000 physicians are added to the pool each year.

However, aggregate physician-population ratios have increased more than twice as fast in the 1970's—2.4 percent annually—as in the 1960's—1 percent annually—and, as I have indicated, highly rural and poor areas have shown very small increases to date.

Although very rural and poor counties have not benefited from the increased diffusion of physicians as yet, we plan to monitor carefully future patterns as the total supply of physicians, dentists, and other health professionals grows.

The Congress and the administration have recognized this geographic maldistribution problem for some years, and measures have been taken to alleviate it. The most effective program which has been developed is the National Health Service Corps and its affiliated scholarship program, which provides a reliable recruitment channel.

We are recommending the continuation of the authority for these programs along with volunteer recruitment. If we were to maintain the proposed 1981 scholarship levels it would lead to an expansion in NHSC field strength. It would result in the placement of a total of roughly 9,600 assignees, including physicians, nurse practitioners, physician assistants, dentists, registered nurses, and others by 1990. This plan assumes about 7,300 service-committed practitioners and 2,300 volunteers.

I think it is important to remember that these numbers are not simply abstract statistics. They represent physicians, dentists and other health professionals actually providing high quality health care to people in need.

This program directly affects the well-being of millions of people—people who not only lack access to health care but who may also often be poor, members of minority groups and living in multiproblem areas. One cannot understand the Corps, its mission or its problems without an appreciation of this human element.

Many States have developed their own student assistance and placement programs to improve the distribution of health professionals in their States. The planning and management of these programs at the State level is often impressive.

We are suggesting that the Secretary be authorized to enter into cooperative agreements with those States to provide for closer accord in the placement of Corps personnel in federally designated shortage areas. This would target all programs toward improving the supply of health professionals in shortage areas.

In addition to the Corps we would continue the program under which we repay a portion of a graduate's educational loans in return for a commitment to serve in a shortage area. Experience has shown that an increased total supply of health professionals and improved financing of health care services cannot alone attract providers to underserved rural and inner-city areas.

Other problems found in these areas—professional isolation and the lack of cultural and educational opportunities—are likely to affect location choices as much as potential income. We therefore need an arrangement to place physicians in these areas with the hope that many will remain. The Corps provides us with that system.

Some of the needs in shortage areas can be met by the services of nurse practitioners and physician assistants. For this reason, we are proposing to make assistance in training for these disciplines conditional on a commitment for service in shortage areas with the same penalty for buy out as for the Corps.

Another key program for meeting the staffing needs of health manpower shortage areas is the Area Health Education Center (AHEC) program, which provides for the enhancement of health professions training opportunities in areas remote from traditional education centers.

The 21 AHEC programs receiving Federal support in fiscal year 1979 were operating or developing 30 regional centers serving over 433 counties in 22 States. Our initial evaluation indicates that AHEC programs are effective in stimulating better geographic distribution of primary care physicians. We would continue this program.

MINORITY AND DISADVANTAGED PARTICIPATION

The third significant imbalance is the disproportionately small number of health professionals who come from minority and disadvantaged backgrounds. Equity demands the correction of this imbalance. The achievement of that equity comes too slowly.

Blacks, Hispanics, and Native Americans comprise 18 percent of the population of the United States but only 7 percent of the physicians. First-year minority enrollment in medical schools has remained at about 9 percent for the past 4 years.

Also, individuals from low-income families continue to be underrepresented in health professions schools. In 1977 the entering students in medical schools from families with incomes below

$10,000 represented 10 percent of all entering students. For the total U.S. population 27 percent of the families had incomes below $10,000. Three years earlier 8.4 percent of the students were in this income range, so perhaps we have started a trend that is in a more favorable direction.

The barriers for students from disadvantaged backgrounds in entering the health professions are twofold. One is financial access. Disadvantaged students are likely to have fewer family resources and to face greater difficulty in securing educational loans than students from more advantaged families. Another obstacle is inadequate preparation for professional training, especially in the sciences. This affects entry into health professions school as well as retention.

We recommend extension of the programs which foster participation by minority and disadvantaged students. The financial barrier is partially overcome by the grant of the scholarship for exceptionally financially needy in the first year of training with no service commitment required for that 1 year of training.

This affords the student the opportunity to embark on a difficult first year of professional study unfettered by immediate financial worries. He or she can then decide after the first successful year whether to seek a National Health Service Corps scholarship or a loan.

We rely primarily on the disadvantaged assistance authority in the current health professions education statute to help bring more minority candidates into the professions. The health careers opportunity program operated under this authority allows us to increase the size of the minority applicant pool and to help entering students become better prepared to succeed in the professional schools.

We have found that over the last 9 years the average percent of minority students enrolled in the first year was 9.3 percent in those nonminority schools which received grants under this program compared with 6.8 percent for schools which did not receive grants.

We believe that the legislative authority which we have requested will enable us to sponsor improved programs to increase minority participation.

SPECIAL PROJECTS OF NATIONAL SIGNIFICANCE

The Federal Government and the educational institutions have joined in creative endeavors to improve the preparation of personnel for health care services. Special project funding has supported innovative activities such as curriculum experimentation and development of newer modes for delivery of services.

We are seeking continuation of special project authorities. It will permit us to fund public health training, programs to redirect nurse training toward priority national needs, projects to improve preparation for service to high-risk groups, such as the elderly, children, and pregnant women, and other special projects of national significance.

THE AGGREGATE SUPPLY OF PERSONNEL

The maldistribution of our Nation's health care personnel which I have described is set in a larger context which is unique in recent history: a rapidly growing and adequate supply of physicians and other professionals. Over the last 20 years the number of active physicians in the United States increased from 251,900 to 447,800.

The ratio went from 1 physician per 692 people in 1960 to 1 physician per 510 people in 1979. The ratio of physicians to population increased by more than 34 percent in the last two decades. This is an unprecedented rate of growth in our country's history. It is a clear result of national policy, program, and funding.

I might say, Mr. Chairman, it is also a great tribute to the educational institutions of this country, which responded so effectively and so dramatically to the expression of need of the American people and to the concerns of the Congress.

Nearly 20 years ago there was a recognition of a serious doctor shortage, which led to Federal programs to aid in building and expanding medical, nursing, and other health professions schools. Those programs succeeded and there is now in place and functioning a capacity to train a supply of professionals which we anticipate will be adequate to meet and exceed our requirements.

Estimates of need for physicians in 1990 range from 444,000 to 574,000, or 181 to 239 physicians per 100,000 population. With a projected supply of 598,000 physicians, there would be between 24,000 and 154,000 physicians above the estimated need.

In 1990 the supply of dentists, pharmacists, and veterinarians may very well exceed requirements.

The ratio of physicians to population is expected to increase by 24 percent between 1979 and 1990.

You have no doubt recognized that I have discussed the nursing profession in the same context as I have discussed the other health professions—that is, the identification of major imbalances and legislative authority to deal with those imbalances. We believe that the continued training of nurse practitioners is critical to progress in meeting the primary care needs of the population, especially the rural population.

The total number of registered nurses has increased from 504,000 in 1960 to 1,100,000 in 1979. This has largely resulted from our success in building the training capacity. Given current health financing policies and utilization trends, we estimate for 1985 that the projected total supply of registered nurses will be in balance with requirements.

Some hospitals will experience difficulty in recruiting for their staffs, but Federal subsidies to expand the aggregate supply are not economical solutions to that problem.

The achievement of a general balance between supply and requirements for health professions was recognized 4 years ago, when the Health Professions Act was last amended in a major review. We reaffirm it now; it is in accord with the current reality. We believe that no provisions should be enacted which would encourage expansion of the training capacity for health professionals.

We therefore recommend the termination of grants for construction of teaching facilities, startup assistance and capitation. We would retain authority for short-term financial distress assistance to needy health profession and nurse training institutions, including those with high proportions of minority students. These grants would be available to promote fiscal stability and to make management improvements.

In general we favor continued restriction on the entry of foreign medical graduates (FMG). However, we recognize that some hospitals, heavily dependent upon FMG's, may require additional time to adjust to the limitation on FMG's imposed by the Health Professions Educational Assistance Act of 1976, and we therefore recommend continuation of authority for waivers for areas where limits on FMG's would cause substantial disruption.

CONCLUSION

Mr. Chairman, I have attempted to outline the course of Federal activities which the administration believes is most likely to lead to a better balance in the Nation's valuable resource of health personnel. The normal functioning of the country's State and private educational system will, we believe, produce the aggregate supply we need.

If we can take steps to correct the imbalances of personnel and simultaneously act on the programs to correct the other health care deficiencies which the President has identified—expansion of primary care delivery programs and broadening the financing base as proposed in the national health plan—we will put in place a well-balanced program to protect and improve the health of the people. We can do this without undue Federal dominance. We are eager to work cooperatively with you toward these ends.

Mr. Chairman, my colleagues and I stand ready to respond to questions.

Mr. WAXMAN. Thank you very much, Doctor. I appreciate your testimony. I am concerned that, while we agree on the basic problem areas—primary care, underserved areas and disadvantaged students—we may disagree on the proper response.

I am especially concerned that you suggest only modest Federal activities are necessary. The problems you enumerate are certainly important. I suspect they are unlikely to be resolved on their own, so that a carefully targeted but substantial Federal effort would still be necessary.

I wanted to ask you, first of all, about the area of primary care. Why don't we now train more primary care physicians and what are the incentives in our current training program so we can produce more primary care physicians?

Dr. RICHMOND. Mr. Chairman, I think you have put your finger on a very important problem, and I dealt with it all too briefly in my testimony. There was a historical trend in this country which was part of the greatness of our medical, health professional educational system, a trend toward increasing specialization, which all of our institutions and our professional associations tended to embrace.

Over time, as our biomedical research contributions increased and as our population came to recognize that there were some benefits that accrued from specialization and indeed from subspecialization, there was a tendency for the educational institutions to focus on these developments and for students and trainees to embrace these developments and to move into the specialties. And, as I indicated in my testimony, in somewhat subtle ways we probably moved too far.

One of the reasons why I say that cautiously is that I come back to the fact that specialization and subspecialization have been associated with improved medical care to a very considerable extent. What we have been trying to do in the past decade is to arrive at an appropriate balance and an allocation of resources to best serve the needs of our people.

By and large, we think we have gone down the road toward specialization and subspecialization as far as is functional and indeed beyond it. So we are trying to redress that circumstance and to strike a balance.

Mr. **Waxman**. Is there any organization, public or private, that now looks at the overall balance of graduate training programs and physicians?

Dr. **Richmond**. Many of the professional associations representing the various disciplines and educational programs in the health professions have done so. I think it is important to note that the Institute of Medicine has, in some of its studies, addressed this problem. And then we have the Graduate Medical Education National Advisory Committee, which is taking a very systematic look and probably, I think, the most detailed look at the allocation.

I think you will recognize, Mr. Chairman, that when we talk about appropriate numbers of specialists, we do at some point get into areas of judgment. And, as I have observed, I can't help but admire the systematic and detailed way that the Graduate Medical Education National Advisory Committee is approaching its work. We anticipate they will be reporting very shortly; they are nearing the conclusion of their work. I think that report will be very helpful.

Mr. **Waxman**. What would you think of the idea of that GMENAC serving the role of consulting with the private sector about improvements in the balance of training programs?

Dr. **Richmond**. I think that after their report has been developed it will become important for the Congress to look at that report and the directions it points to. It will be, I think, useful for those of us in the executive branch as well as all of the professional and institutional membership organizations to do that as well.

So I know we will be looking very, very carefully at how one proceeds to act on the recommendations that they will make. We certainly will evaluate those recommendations.

Mr. **Waxman**. We all look forward to the recommendations, but my question to you was: What would be your impression of keeping the GME Committee in existence and assigning to it the role of consulting with the private sector about improvements in the balance of training programs?

Dr. **Richmond**. I think that could be a useful role for that committee. I think your earlier question suggested involving the institutional membership organizations and professional associations as well. I think that would be additionally valuable.

Mr. **Waxman**. What have you done with respect to the reimbursement system? I understand that studies show doctors earn more in well-supplied areas than in rural or inner-city areas, so our reimbursement system rather discourages distribution geographically. Have you made proposals to change the reimbursement system or do you have any suggestions for us to change it?

Dr. RICHMOND. I think that in an open society like ours, it is, of course, difficult to change patterns of reimbursement quickly; but we have, in consultation with the Health Care Financing Administration, asked them to look at ways by which rural practitioners, for example, would be reimbursed at rates that are not unfavorable compared to those who practice in urban areas.

There has been a tendency for even publicly funded reimbursement programs to have the kind of discriminatory differential. We also think the approach of health maintenance organizations, which we have been emphasizing, is another effort to move in the direction of more equitable distribution.

Certainly the Rural Health Clinic Act, which made it feasible for the rural health clinics to collect fees for service of nurse practitioners and physician assistants, is a step in that direction as well. So we do have a number of developments under way that I think will be helpful in this connection.

Mr. WAXMAN. Do you think that if we would reimburse providers to go to underserved areas at a higher rate, that would be more attractive for physicians and other providers to go to these areas?

Dr. RICHMOND. We are not certain, unless one gets those differentials up very high, that that would necessarily work. There are just so many other aspects of how people like to live and where they like to live that create problems.

However, the program that Dr. Martin directs in the Bureau of Community Health Services has made it possible to reimburse physicians who go into rural areas. It also makes it possible for us to provide more attractive practice opportunities and continuity of care opportunities so that, if some physicians leave those centers, we have new ones coming into centers. Thus we are trying to institutionalize patterns of practice in difficult-to-serve areas.

Mr. WAXMAN. I want to ask some questions about geographical distribution. But before I get to that, we were talking about primary care physicians and I would like to hear your definition of primary care physicians.

Dr. RICHMOND. I would define a primary care physician as a person who is based in a community who provides first contact to the medical care system, who is interested in comprehensive care and who provides linkages from that primary care setting to the secondary and tertiary medical care facilities—in other words, consultation with the secondary care system and tertiary care system as patients present problems which are beyond his degree of specialization and competence.

Mr. WAXMAN. Would you include, in primary care, elements of continuity, psychologic support and prevention?

Dr. RICHMOND. Yes; those are the things I would put under my term of comprehensive.

Mr. WAXMAN. Dr. Martin, what do we know about the supply of physicians in rural and inner-city areas?

Dr. MARTIN. There is a great deal of information that has been discussed recently, much of which has been developed by Dr. Foley's agency, HRA. I think the observations which Dr. Richmond clearly discussed regarding the differential gains over the last 10 years, are important issues.

While there is clearly a significant increase of physicians in general, we have seen no increase in those areas which are the poorest served and often in many of these areas we have seen a substantial decrease in physicians available. That is particularly true in the worst inner-city areas. There are, for example, parts of Harlem, parts of the south Bronx, parts of other urban cities—Chicago, Los Angeles—where there is a substantial out-migration of physicians. A study done in Chicago recently, for example, showed that the overall numbers showed no increase whatsoever.

As I indicated, Dr. Foley's agency has done numerous studies on this, and I might defer to Dr. Foley to add or expand on my remarks.

Mr. **Waxman**. What about the trends. Are we seeing more young physicians going into the really underserved rural and inner-city areas?

Dr. **Martin**. I think there are two important trends. I think many of us, particularly young physicians, like to believe that the last two generations of young physicians not only went into those shortage areas but they saw patients who were the most desperately in need of care.

A number of studies have shown clearly that the proportion of those two generations of physicians going into those areas is strikingly less than three or four generations ago, and an unpublished study by Dr. Madison, for example, has shown that generally they go in to practice with four or five other physicians.

It is unfortunate but I think it is a fair statement that the last two generations of these trained physicians whom we are talking about generally are not on their own going into the isolated rural areas as did their predecessors nor certainly into the inner cities.

Now, the exception is when there are organized programs like the community health center program or the Indian Health Service. About two-thirds of the people eligible and receiving loan repayment, for example, in shortage areas are employed through the NHSC and the IHS and only about one-third are in private practice.

I think what is of most concern to us in the communities we are looking at is the proportion of young physicians accepting medicaid assignment. The difference, for example, between practitioners in the last decade accepting medicaid assignment and three decades ago is substantial. Basically in three States where an in-depth study was done, only one-third to one-fourth as many of the new graduates were taking medicaid assignments, as were the older physicians who were well established in those communities.

The impact, of course, of both of these factors is that, in spite of our reluctance to want to believe ill of the generation of physicians we represent, there is a serious problem for the future if the present trend continues. And there is certainly no evidence to indicate that there is going to be a substantial change in that.

Mr. **Waxman**. In our bill H.R. 6802, we propose that the National Health Service Corps assign practitioners to public and private organizations that agree to employ these individuals. Is this a reasonable approach and would there be administrative difficulties with this?

Dr. **Martin**. I think the program feels that it is a reasonable approach, partly because there has been an effort in the last 2 years by the Public Health Service to interpret the present private practice option broadly and because we are proposing in the administration bill to modify and extend the private practice option.

Implicit in the previous statute was the implication that it was compatible with the intent of the statute for individuals to seek to go into shortage areas on a salaried basis and work in group practices in high priority areas. And this certainly was a priority for the efforts that we were beginning to make in the program.

The administrative difficulties, I think, largely will arise out of possible specifics in the committee's proposal. We are looking at those in some detail and the Department will be responding to those, I think, in the context of a response to the broader issues within the bill.

Dr. **Richmond**. I think, Mr. Chairman, if I might interject here, that we are concerned that these physicians not be drawn into predominantly administrative posts, which certainly with some of the public agencies could be a tendency. Our major effort is to try to get these physicians into primary care settings, which we define as having the greatest need.

Mr. **Waxman**. Could that be handled administratively?

Dr. **Richmond**. It is suggested that we keep monitoring this and trying to minimize that trend.

Mr. **Waxman**. Do you see any other administrative problems?

Dr. **Richmond**. No; I think this is a matter largely of making certain that, regardless of the auspices under which the people work, they are serving in the areas of greatest need.

Mr. **Waxman**. Dr. Richmond, I would like to know your evaluation of our existing disadvantaged programs as to whether they are adequately targeted. What about the mix between funds for community groups and schools? I understand that some people suggest that a larger share of the money go to the schools. I am interested in your impression.

Dr. **Richmond**. I wonder if I might ask Dr. Foley to make some comments on this, and I might elaborate, too.

Dr. **Foley**. Mr. Chairman, we have seen a profusion of groups who have applied for funds under the disadvantaged assistance program. Many of them are doing quite well in terms of recruiting and retention, particularly in the recruitment of minorities into their schools.

But our concern is that the institution itself—that is, the medical school or the particular health profession school that the minorities are being recruited for—needs to feel a sense of ownership and possession about the recruitment activity.

So we have recommended that in the future the funds under this program—although continuing to go in parts to private nonprofit groups would go largely to institutions so the institutions themselves would, on an ongoing basis, recruit and retain minorities in the health profession schools.

Our expectation would be that at a certain point in time we would no longer need to continue such activity each year nor request funds from the Congress. I think that we are looking, however, at perhaps a 5- to 10-year period to try to get those institutions really to move in a fairly aggressive way more than they have so far.

I think the data we shared with you today shows that, in those schools which are not minority-dominated now, we have seen an increase by funneling students into those schools in contrast to those schools which did not have a program. That is why we recommended targeting of our funds in this program to the health professions institutions themselves.

Mr. WAXMAN. What private nonprofit groups have funds for disadvantaged student recruitment?

Dr. FOLEY. We have seen various organizations in the Hispanic community and the black community as well as the Native American community receive funds and then go out and try to reach, through their organizations, young students who would be basically candidates for the health professions.

We think that that has reached a point where we basically have been saturating quite well through that structure but now need to turn the funds more in the direction of the institutions I have mentioned earlier.

Mr. WAXMAN. What kind of monitoring do you do of those private nonprofit groups that receive money?

Dr. FOLEY. We have, through the Office of Health Resources Opportunity, which is in the Health Resources Administration. We have a very active program to check on projects. In this past year we have found, through a combination of inspections by the Inspector General's Office, our own regional office, and my central office, a particular case in which we felt that funds were not being appropriately spent.

We closed out the grant to that particular community group because we felt the program was not appropriately supported by Federal funds and did not meet the purposes or objectives for which the grant was made.

Mr. WAXMAN. Where was that?

Dr. FOLEY. Kansas City, Mo.

Mr. WAXMAN. So you think the bulk of the money ought to go to the institutions. And what do you foresee the institutions doing with the money?

Dr. FOLEY. In some of the institutions—in particular schools in the Northeast—a program is of a remedial nature in basic sciences, for example, related to either medicine or osteopathy. We have seen some positive results, particularly with those schools which conduct summer programs in which undergraduate college students, or in some cases even high school students in their fourth year, are brought in and exposed to the basic sciences. These remedial programs prepare the students to take examinations to go into medical school and into other health professions schools as well.

We think that such programs are a better targeted use of the funds and result in the health professional school's developing a sense that they can indeed recruit and retain minorities.

In one particular State in the Southwest; students from minority backgrounds who were already in the medical school received special remedial training in the course of the year, not only in the 9 months but in the 3 summer months as well. These students' success rate in medical school was much higher than that of minorities in other schools in the same locale.

Mr. **Waxman**. What new programs do you think we might try to improve the number of disadvantaged students going into the health professions?

Dr. **Foley**. What programs?

Mr. **Waxman**. Do you have any idea of new programs or, aside from giving the money to the institutions, are you satisfied with the existing programs?

Dr. **Foley**. I think, a major challenge perhaps not only in this area but in other areas, is to improve the public school systems in this country and some of the public university and community college systems in which we are seeing lately a regression of the kind of progress we saw in the fifties and sixties and perhaps even in the early seventies, such that minorities are not doing as well in their entrance examinations for either college or graduate types of educational programs.

I think we need to look at the quality of that education because we are oftentimes talking about the basic science curriculum of the secondary school system as well as the undergraduate level and the exposure of minority populations to those systems.

I think the challenge is to focus on needs in the secondary school systems, the undergraduate school systems, and the community colleges.

Mr. **Waxman**. Every time I asked about disadvantaged students, you responded by talking about minority students. Do we have economic disadvantage as the criterion for taking advantage of the money under this program or is it solely whether they come from a group you would characterize as minority aside from whether they have economic disadvantage?

Dr. **Foley**. We include nonminority populations, although to be candid, I think the record does show that in the last couple of years the program has reached out more to minorities than to nonminorities. We have a report from the GAO to that effect and we will be in the process of correcting any imbalance in program emphasis.

There is no question that low-income populations of Anglo background or nonminority background in this country have some of the same legitimate concerns as the minority populations. There are areas of the rural Rocky Mountain region and certainly Appalachia with populations needing exposure in terms of basic curriculum so that they can enter into the health professions.

Currently, we do have some programs in the Appalachian region which reach out to low-income, economically disadvantaged nonminority populations, and we will continue that work.

Mr. **Waxman**. Dr. Foley, I know you run the substantial disruption waiver program. How does that work?

Dr. **Foley**. We have conducted the program in the past 1½ years in cooperation with the immigration authority, and we have run it rather tightly. Congress in 1976 indicated to us that there must be substantial disruption of health care service for a waiver to be granted for certain foreign medical graduate students coming to this country for graduate medical education.

We have seen a reduction in the number of foreign medical graduates coming into the country. In this past year, the Substantial Disruption Waiver Review Board, has granted 300 waivers; 334 were requested; we turned down 34.

The waivers primarily are concentrated in the New York City health and hospital systems and in the private hospitals there and in New Jersey.

These foreign physicians are separate from the foreign graduates who qualify for entry through the visa qualifying examination. That is a separate program.

In terms of the substantial disruption waiver authority, we have run it very tightly. When we grant a waiver to a specific hospital to accept this type of physician, we require that the hospital show improvement in the next year, that they no longer have as great a dependency, if any at all, as in the previous year.

So, in the case of the New York City health and hospital system and the private hospitals in New York State and New Jersey, we have told them that, if they come back next year requesting the same or a higher number of foreign physicians they will be turned down. In fact, we have turned down several hospitals in that part of the country as well as in other parts of the country.

I think the amazing aspect of this is that there have been only 330 requests. I think the intent of Congress is being met. I think that many of the hospitals in the large urban centers are reducing their dependency, particularly in the areas of Chicago, Cleveland, and Boston. We are showing progress, and we want to continue that progress.

Mr. **Waxman**. So those posts which were previously held by FMG's are now being held by U.S. medical graduates?

Dr. **Foley**. That is correct.

Mr. **Waxman**. What experience do you see for the program if the waiver period is extended for 3 years, as the administration proposes?

Dr. **Foley**. We see a gradual reduction of dependency by the hospitals to which we have currently granted the waivers. Our concern has been in the New York City area where, when Congress passed the act, foreign medical graduates, represented in some cases 95 percent of the house staff in the specialties of radiology, anesthesiology, psychiatry, and child mental health services.

While we have seen some progress, we expect to see over the next 4 to 5 years a further reduction of that dependency since we have the criterion that unless the hospitals reduce the number of foreign graduates they are using each year, we will not grant them a waiver. We think the progress will be there.

But, at the same time, if we were to just simply stop the waivers completely as the law expires, those hospitals in New York and in New Jersey would not have the needed health care services, and there would be disruption.

I think I should add that we have reached out to New York State in regard to the eight or nine medical schools in the New York City area, suggesting strongly that New York State itself has a responsibility, since it is putting so much funding into those medical schools, to try to encourage the deans and others to encourage their students to practice in the hospitals in the New York City and New Jersey areas and in Connecticut.

Mr. **Waxman**. In light of the fact that a medical student can look to an income above the average in this country, do you think unsubsidized market rate loans might be an appropriate approach to the support of health professions students, particularly the medical students?

Dr. **Foley**. We do, Mr. Chairman. We estimate today that the average family of four has an income of approximately $20,000. For physicians who come into practice today who do not go into rural areas in the United States, the average income is $60,000 plus. And we expect that this income is going to increase, as it has over the last 5 years.

There is no question, we think, that physicians can incur an indebtedness during their 7 years of training and pay it back from the net income that they will receive in their first year and the subsequent 15 years.

We estimate that the average bite into a physician's income in the first year would range anywhere from 8 to 10 percent, depending upon the part of the country in which he or she would be practicing.

Now, we do recognize that physicians who go into rural areas and into underserved inner-city areas would not receive income as high as that of physicians in other areas. That is why we have recommended scholarship programs that have a service requirement.

We also recognize that there will be further difficulty for these physicians. In regard to what you have asked us, we are considering reimbursement changes. I expect that in the near future the Department, after some consideration, will come back with some recommendations to the committee and to the other committees in the Congress. The reimbursement question is critical in this case, particularly for rural areas and underserved areas.

Mr. **Waxman**. Do you think an unsubsidized market rate loan would be the approach satisfactory for the education of other health professionals?

Dr. **Foley**. Not for nursing. There we see the programs in the Department of Education—the National Student Defense Loan program, the guaranteed student loan program, and the basic opportunity grant program—as being used by the nurses at the undergraduate level.

There is no question that to suggest nurses could absorb a tremendous amount of loan indebtedness, given the payment they receive after graduation, would be unrealistic. We have pushed very strongly for a further opening to nurses of the programs under the new Department of Education.

Also although the incomes of dentists are not as high as physicians' incomes, they are fairly high. We feel that dental students can incur the kind of indebtedness we have suggested.

In regard to other areas, pharmacy students are basically undergraduate students who can be aided under the Department of Education's programs. We do recognize that students who go on for another year or two in clinical pharmacy may have to seek out other funding.

Mr. **Carter**. Mr. Chairman, if the distinguished gentleman would yield on that, according to a study of the health educational assistance loan program, the so-called HEAL program, a medical student borrowing $8,000 a year at 12 percent interest would have to repay a total of $148,000 or $822 a month for 15 years starting 3 years after graduation in order to liquidate the debt.

That is a tremendous amount of money for anyone to have to pay back as I see it. And with the interest rates going up as they are today, the repayment total is likely to go even higher. Thank you, Mr. Chairman, for yielding.

Mr. **Waxman**. Thank you, Dr. Carter.

Dr. Foley or Dr. Richmond, what does the administration propose to do about the HEAL program? Do you propose to locate it in the Education Department or keep it where it is?

Dr. **Foley**. We expect it to come back to the Department and to be under the administration of the Public Health Service and the Health Resources Administration. We are in the process of negotiating now for staff to return to run that program and expect that this issue will be resolved in the near future.

There is some question of whether the program will come back to the agency as a direct program or whether it will come back on a reimbursable basis, as with the HUD 242 program. The Department will be consulting with the committee as well as with others about that in the future.

Mr. **Waxman**. Please keep in consideration during your negotiations the fact that I offered an amendment to the Department of Education bill which specifically would exclude the health programs from the Department of Education. We felt, and the Congress agreed, that those programs appropriately belong in HEW and not in the Department of Education.

What about students from low-income background? Does the current exceptional financing need program meet their needs?

Dr. **Foley**. We feel that it does. We think that it allows the student to have 1 year of experience in the health professions school, particularly in medicine, and then provides the opportunity for that person to search for other funds after the first year. We think the program is an excellent feeder program for students from low-income and disadvantaged populations, into our health professions schools.

Mr. **Waxman**. Dr. Richmond, I know that you are interested in strengthening our prevention programs. What about support for schools of public health? Are you really sure they can get along without some Federal assistance?

Dr. **Richmond**. No; I think this is one of the areas in which we have suggested some continued assistance. We do feel that, in the light of our expanding programs in prevention and our great need for people who are trained in epidemiology and toxicology, we still need to enhance the capacity of those institutions to turn out such personnel. They are in very short supply. So we would propose continuation of support for those schools.

Mr. **Waxman**. The last authorization of the Nurse Training Act required HEW to arrange with the National Academy to study nursing shortages and Federal programs to end them. The preliminary 6-month report is to come to us by the end of April. Can we expect that report on time?

Dr. **Foley**. This April, Mr. Chairman?

Mr. **Waxman**. That is the provision in the law.

Dr. **Foley**. The answer is no, and the reason is as follows: Congress passed the act rather late in the last session. We have, consistent with the congressional intent, moved rather aggressively with the Institute of Medicine. We have signed an agreement, and we are now in the process of working with them.

The difficulty we have is that there was no line item in the appropriation for that report in the last session of Congress. We went back to the Appropriations Committees to ask for a reprograming in a particular line to pay for the study with the Institute of Medicine. That reprograming was rejected by the Appropriations Committees in the Senate and the House. We will be going back to them with another request.

We will be looking at the 1-percent evaluation funds under our program in the Department to pay for the study. The practical result of those steps, we believe, is that the Institute of Medicine will provide us a report the first week of November of this year, which we would forward to the Congress.

It will be more than just a planning report; it will be a progress report on the key issues in the area of nursing. Then the Institute of Medicine will continue the study over the next 24 months and come in with a final report.

So while we are not going to meet the specific time frame set in the conference report or in your discussion last year, both because of the lateness of the passage and signing of the act and the question of where we are going to get the funds to do the study we have now worked those problems out and we are moving ahead.

Mr. **Waxman**. Just for the record, the bill was passed in September and the time was 6 months thereafter. So the lateness of passing the act and having it signed really should not have had any bearing. The 6 months didn't run until it was passed.

Dr. **Foley**. Mr. Chairman, it is also the reprograming of the money. You directed us to follow through on this and, when we were looking for a fairly sizable sum of money to perform this study appropriately with the Institute of Medicine, we had to go through the appropriations process.

Our first suggestion for funding was rejected for reasons that are in the record, and we are, therefore, going back to the Department to ask to use the 1-percent evaluation funds. IOM is not part of the Department's staff. We have to pay them for their activities, and funds had to come from the Health Resources Administration's budget within the Public Health Service.

Mr. **Waxman**. The administration proposal is predicated upon an estimate of adequate nursing personnel through 1985. The report might indicate otherwise but I have over 1,200 news clippings all taken within the last 6 months from newspapers in 40 States which all point to significant local shortages of staff nurses. Would you tell us the date and source of your statistics and how you arrived at the estimate?

Dr. **Foley**. Mr. Chairman, in cooperation with the various nursing associations, particularly the League of Nursing and others, we have been sharing the same data for the last 7 years. There was a survey done with the base year as 1972 and updated thereafter. The latest data we have are for 1977, and that is the year we are now using. That, I believe, is the year which most of the associations are using as well. So we are using the same data source.

I think the question that has arisen is the question of the vacancies within the hospitals rather than the aggregate number of nurses.

Mr. **Waxman**. The Division of Nursing reports that there are 111,000 nurses graduating each year and that 99 percent find jobs. The division also reports that there is an annual net loss of only 1 percent of the work force. How do you reconcile this high placement and employment rate with the fact there are not enough nurses?

Dr. **Foley**. We are looking at two levels of nursing, both the RN's and the LPN's, the licensed practical nurses. Our projections indicate that with the capacity we have built at the undergraduate level, particularly at the AA level as well as the 4-year undergraduate level, we are producing sufficient numbers of RN's. We also have those persons who are coming out of the community colleges in the licensed practical nursing program.

We do recognize that we have vacancies within the hospitals. Our position has been that the hospitals themselves need to address the matter of incentives, the reasons why nurses are not staying within the work force within those hospitals also, the pay level needs to be considered by the hospital administrators as well as the morale factors that the nurses are being exposed to.

We do recognize that there is a serious vacancy rate in some hospitals, but we think the incentive system within those hospitals needs to be improved to correct that imbalance.

Mr. **Waxman**. How much was cut from the nursing loans and scholarships in fiscal year 1979?

Dr. **Foley**. Mr. Chairman, the budget for scholarships in 1979 was $9 million. The loans would be $13,500,000.

Mr. **Waxman**. Do you think that relates to the drop in enrollments in nursing schools by 3,000 students this year, the estimate from ANA?

Dr. **Foley**. I think, candidly, we don't know at this point. We are looking at that pretty carefully. We do think that student support needs to be available through the Department of Education and that the officers in the colleges, including the community colleges, where students need support ought to avail themselves of the funds under those particular provisions.

Mr. **Waxman**. Dr. Carter.

Mr. **Carter**. How much have you included in your bill for financial distress grants to medical schools?

Dr. **Foley**. For fiscal year 1980, $5 million, Dr. Carter.

Mr. **Carter**. $5 million? Do you think that will——

Dr. **Foley**. Excuse me. We also requested an additional $2,400,000. So the total is of $7,400,000.

Mr. **Carter**. What was the total, please?

Dr. **Foley**. $7,400,000.

Mr. **Carter**. I thought it was a little more. Do you think that would permit Meharry, Morehouse, and the other minority schools to continue operations?

Dr. **Foley**. We think in those three cases of Meharry, Tuskegee, and Xavier—not Morehouse—that we do have enough funds to deal with their requests at this point. Certainly in the case of Xavier and Tuskegee we do not see further difficulties. I think in the case of Meharry we do have some concerns.

Mr. **Carter**. Are you concerned that there are not enough funds for Meharry?

Dr. **Foley**. Concern reiterated by the National Advisory Council on Health Professions Education that with regard to whatever funds go to Meharry there be appropriate management controls and audit controls so that we know whether the funds that go there are sufficient or insufficient. Dr. Carter, at this point we don't know——

Mr. **Carter**. I want to tell you that I have been in conference with several gentlemen representing these different schools, and my impression after talking to them is that $7.4 million would not be nearly enough. So for that reason I introduced today a bill to authorize $25 million for financial distress grants. And even if this proposal is appropriated to the full amount, I doubt seriously that it will be enough.

Just as an aside, I thought that I might tell you about an experience I had as an Appalachian doctor. Frankly, I am very proud to be an Appalachian doctor because I like that area of the country. I like the hills, the mown meadows, the clear streams, and the entrancing woods. I can't see why people don't want to go there. I have really enjoyed it. If I had been made of steel I would have been there today. I am going back.

While I was there I had a registered nurse who worked for me. We had an old gentleman who had arteriosclerotic gangrene of the left leg and who refused to go to the hospital. So we had to get into what they call a canoe and cross Big Sulfur Creek to go to his house. By the way, we rode across Big Sulfur in the canoe with John Harris Harris, and the patient in question was Mr. Andrews.

It seems that Mr. Andrews had divorced his wife and she was then married to John Harris Harris, the man who rode us across the Big Sulfur, if you follow me. And John Harris Harris had been married to W. Andrews, the daughter of Mr. Andrews and Mrs. Harris, who had been Mrs. Andrews. The present Mrs. Harris, who was now married to Willie Hunter, was there, too.

Under local anesthesia we removed the left limb of Mr. Andrews. And, you know, all of those people continued to live seemingly happily ever after in that little five-room house on Sulfur Creek.

This is an authentic story and can be verified. I thought you might be interested in that. That was just a little digression but something that actually happened. I enjoyed it thoroughly. And, you know, the old gentleman got along just famously. I was very pleased at that even though his leg was removed on the kitchen table.

Returning now to our earlier discussion about loans, I was wondering, how students are going to cope with loans at such high interest rates. I believe the prime rate is now 19 percent, yet you recommend that medical students borrow at that rate if it is necessary, is that correct?

Dr. **Foley**. I do not recommend that anybody in this country borrow at 19 percent, Dr. Carter.

Mr. **Carter**. How are they going to medical school, then, if they need money?

Dr. **Foley**. When we made our projections, it was assuming either an 8-percent or 10-percent inflation rate. When the rate starts getting up to 19 percent, we are seeing a very difficult situation.

Mr. **Carter**. What is the prime rate at the present time?

Dr. **Foley**. The prime rate today is 19 percent.

Mr. **Carter**. Now let us face facts. If a student chooses to go to medical school, that rate goes to only the best borrowers, does it not?

Dr. **Foley**. That is correct.

Mr. **Carter**. All right. And instead of $8,000 a year if one goes down here to Georgetown, the tuition would be very high. What is the tuition there at the present time?

Dr. **Foley**. The tuition is over $13,000.

Mr. **Carter**. $13,500 I believe. Instead of an annual cost of $8,000, you would project $13,500 over a period of 4 years and, instead of owing $140,000, what do you project the Georgetown graduate would owe then, under the HEAL program? I believe it would be almost twice as much, since the interest rate has doubled.

That is quite a large amount of money, isn't it, for one to owe even if he makes $60,000 a year?

Dr. **Foley**. Dr. Carter, I would hope that we do not pass programs on the basis of our current inflation rate. I think you and others are trying to bring it down. It is a very serious problem. Take the student who is going to go to Georgetown today. If his tuition there is $13,000 plus, I would recommend that he move to Texas, take up residence and go there for $600 and serve in some of the underserved areas in that particular State.

Mr. **Carter**. I think so, but if you go to school and have to pay 19-percent interest, what are your charges going to be? Would the charges have to increase? They'd have to go up, in order for students to pay this debt.

Dr. **Foley**. That is correct.

Mr. **Carter**. What are you doing with that high interest rate? You are firing the furnace of inflation right there, aren't you?

Dr. **Foley**. Doctor, we are trying to bring that inflationary rate down with your help.

Mr. **Carter**. Leave it to me and I will do it today. I will bring it down to 10 percent. As you know, the interest rate is determined by the Director of the Federal Reserve Bank. Currently he sets the rates for loans at 13 percent for regular members and 16 percent for frequent borrowers. Because most banks require a 2-percent margin, the actual rates would be either 15 percent for the less-frequent borrowers or 18 percent for the frequent borrowers, at least that. Our larger banks would probably have to borrow at 19 percent.

The only thing you have to do, as Wright Patman from Texas said, is to set the Federal Reserve Board exchange rate reasonably.

I think Mr. Volcker could do that. If he did, he would ease a lot of pain in this country at the present time, because there has been an increasing number of bankruptcies and an increasing number of small business failures. For young couples the vision of a home has vanished into thin air with the economy as it is.

Yes, I want to help you control inflation and I want to help you bring that interest rate down, not just for medical students but for everybody, and I believe it can be done.

Mr. **Dannemeyer**. Would the gentleman yield?

Mr. **Carter**. I would be happy to.

Mr. **Dannemeyer**. You know, there is another theory on how to reduce interest rates, Dr. Carter. We in the Congress have the capacity to reduce interest rates in this country within 30 days by at least 4 to 6 points. All we have to do is to exercise the political discipline of cutting the fiscal year 1980 budget by $40 to $60 billion. By so doing, the Federal Government would not be borrowing the funds to cover the current deficit which would reduce the pressure on the credit markets, which in turn would drive down interest rates for everybody in this country.

The Congress of the United States is the agency responsible for the high interest rate, not the Federal Reserve Board.

Mr. **Carter**. You know I hate to disagree with you, but I think you are entirely wrong. Usually you are very articulate but in this case, I disagree. In my view the interest rate is exactly what the Federal Reserve Board Chairman says it is, contrary to what the gentleman says.

Now, let's return to capitation. I understand it amounts to only 2 percent of the income which medical schools have today. Is that correct?

Dr. **Foley**. About 2 percent of their revenues.

Mr. **Carter**. However, they receive other revenues, do they not?

Dr. **Foley**. Yes, they do, Dr. Carter.

Mr. **Carter**. What percentage do they get from biomedical research, for instance?

Dr. **Foley**. I have those figures for you.

It is 19 percent.

Mr. **Carter**. 19 percent? That figure has decreased, too, quite a bit over the years, has it not?

Dr. **Foley**. Yes, it has. It has gone down.

Mr. **Carter**. Thank you very kindly. And, by the way, Bill, if you will bring that interest rate down, as you said you would, I think you ought to run for President. Thank you, Mr. Chairman.

Mr. **Waxman**. And now the next President of the United States.

Mr. **Dannemeyer**. Am I next?

Mr. **Waxman**. I recognize Mr. Dannemeyer.

Mr. **Dannemeyer**. Thank you, Mr. Chairman. Dr. Foley, if I understand this budget for 1981, you suggest that we spend $426-million-plus to encourage and assist in of developing people for the health care industry. Is that a fair statement?

Dr. **Foley**. The administration's bill has a total authorization level of $426 million.

Mr. **Dannemeyer**. And it is fair to say that this sum represents taxpayers money designed to encourage the development of health care in this country; is that a fair statement?

Dr. **Foley**. Yes, to populations throughout the country who need it.

Mr. **Dannemeyer**. If that is the policy we should adopt, as the Congress, I would like to contrast it with a statement made by the good Dr. Richmond on page 14, at the bottom of the page, where he says: "In general, we favor continued restriction on the entry of foreign medical graduates."

I am puzzled by that statement. If it is in the interest of the taxpayers of this country to spend $426 million of the taxpayers money to encourage the development of people trained in delivering health care services in the next fiscal year because we need those services, why in the world should we, as a matter of policy, also, follow this suggestion to place restrictions on foreign medical graduates who perhaps have achieved their education at their expense and at no cost to the taxpayers?

Now, as a consumer and a taxpayer in this country, I am interested in your logic as to how you reconcile those positions. Since it is Dr. Richmond's statement, perhaps he would like to answer.

Dr. **Richmond**. I think, Congressman Dannemeyer, what we have been striving for in this country is to bring us to the point of self-sufficiency in terms of health personnel trained in our institutions and by our standards. We think that we can do that. We think that the people in this country want that kind of health care.

I think there has been the additional concern that we have had that, by having unrestricted entry of foreign medical graduates to the United States, we are depriving——

Mr. **Dannemeyer**. Wait a minute. My State of California licenses graduates to determine that they have proficiency in administering health care to people, right?

Dr. **Richmond**. Yes, the State has the licensing——

Mr. **Dannemeyer**. If the person can pass the test establishing ability to deliver services, what difference does it make where he has been trained, whether in Tibet or Mexico or South Carolina?

Dr. **Richmond**. Mr. Dannemeyer, what State licensure does, as you indicated, is to provide a floor and it minimizes any possibility of substandard care. But we think that what the American people, by and large, have been striving for is excellent care.

I think that there is a concern that the graduates of our institutions, by and large, do provide a higher quality care than the heterogeneity of backgrounds that the foreign medical graduates bring with them.

Mr. **Carter**. Will the distinguished gentleman yield?

Mr. **Dannemeyer**. Surely.

Mr. **Carter**. I will tell you about a little incident. Not too long ago I was in Laurel County and the county clerk called me in about a man who was insane and who ought to be committed. I called up and I got an FMG. It was very, very difficult for me to understand him. He was a psychiatrist, and I wonder how in the world he ever communicated with patients. If there ever was a doctor who needs to communicate with a patient it is a psychiatrist. And this man had extreme difficulty in communicating.

Mr. **Dannemeyer**. Was he born in some other country?

Mr. **Carter**. Yes; he was a FMG, foreign medical graduate.

Mr. DANNEMEYER. From the standpoint of a consumer and taxpayer, in my home State of California we have a lot of students who can't meet the high standards of our medical schools, so they go down to Mexico and train down there. And conceptually I don't see any reason why, if the function of examination is to determine a proficiency to deliver a service—and I think we have to agree that is the function—and the student can pass it, what difference it makes where he comes from?

It disturbs me that you, in your position would say that, from a national policy standpoint, we should restrict the ability of these young people to get into our medical service field in this country. We are spending taxpayers' dollars on the one hand to encourage the development of people to deliver health care while, on the other hand, when we get a person who has sufficiently wanted to be a doctor that he has gone to another country to study at his own expense, you are saying we should not welcome that person.

Dr. RICHMOND. There are two kinds of foreign medical graduates. There are those who are U.S. citizens and have gone to medical schools abroad and come back and received their licensure. Some have had excellent training but many have received their training under great difficulties. And, while some of them may pass their examinations, many times their training hasn't been of the high standard that we think the American people have wanted through the kinds of educational institutions they have established.

The other point I would make is that in my testimony I point out that we have arrived at the point where we are producing from our own institutions sufficient numbers. And we see little reason to go in the direction of having students come from abroad.

Mr. DANNEMEYER. I hear you but I tell you that I am a consumer and a taxpayer Representative around this place. And legislatively, periodically we try to repeal the law of supply and demand. We will never be able to do it politically but we keep trying.

Nobody is ever going to be able to convince me, no matter how many statistics he has, that if we consumers want to drive down the cost of medical care it would be wrong to have more people working in the field and that the law of supply and demand would not work to our benefit. That is the reason I am making the statements I am.

Dr. FOLEY. I just want to clarify, consistent with what Dr. Richmond mentioned, that in his statement he is talking about foreign medical graduates who are not U.S. citizens. We are not talking about U.S. FMG's who do come back to this country and go basically through a fifth pathway program into the medical schools so they can practice. The restriction is not in that area.

I think that Dr. Carter has identified a very deep concern that we have about the consumers not being able to receive adequate service from some of the foreign medical graduates. Second, after much discussion here in these halls and within previous administrations, we have come to the conclusion that it is about time we quit taking other countries health professionals into this country when those professionals are in developing countries that don't have enough services.

I have just come back from India, where 80 percent of the population is in 60,000 rural villages. They have malaria and filariasis and have fantastic cervical cancer rates. And they are asking for our help. The last thing we should be doing is taking physicians out of developing countries and bringing them here. We should encourage them to stay in their countries and provide the needed services there.

Mr. **Dannemeyer**. I say that it is a good policy objective to encourage them. The way the market system should encourage them is by providing the incentives for them to stay in their countries and work there. And they will do that. It is not the function of a free society to restrict the movement of human beings just because someone in a position of authority thinks he or she is better able to determine how a person should invest his life no matter what country he or she comes from.

Mr. **Waxman**. Would you, then, favor removing all immigration barriers into this country?

Mr. **Dannemeyer**. I think economic incentive is a legitimate element that drives people. And if people can get into this country within the confines of our existing needs, our immigration policy should permit that.

Mr. **Waxman**. The incentives are not just for our needs. The incentives are for their needs. And I think if we were to open the doors to all people everywhere who wished to come to the United States, we would find people flooding here.

Mr. **Dannemeyer**. I am not suggesting that we modify our immigration quotas by any means at all. I am just suggesting that if there is a need in India, for instance, to keep doctors there, my response would be to make the incentive such in India that graduates of medical schools will want to stay there and that they will stay there and work.

Dr. **Foley**. We hope that happens, but the statement on the FMG's is consistent with our immigration policy, and that is why we made it consistent and constrictive—consistent with the immigration policy you just mentioned.

Mr. **Carter**. If the distinguished gentleman would yield, I would like to ask my good friend: Does your physician speak English?

Mr. **Dannemeyer**. My physician? The last time I talked with him he did.

Mr. **Carter**. I see you have made a good choice. I want to compliment you on that.

Dr. **Richmond**. Mr. Chairman, I would like to just indicate that, since Congressman Dannemeyer has suggested that perhaps we are acting arbitrarily or through our own authority, I think, as Dr. Foley has indicated, I believe, in considerable detail, we have been trying to carry out the intent of Congress. This is not our own action that we are taking; we are trying to implement what is a statute of this Congress.

Mr. **Dannemeyer**. I appreciate that. Thank you, Mr. Chairman.

Mr. **Waxman**. Let me thank you very much for your presentation to us today. We will look forward to working with you as we address this legislation and try to work to deal with those problems which you describe in your statement, Dr. Richmond, with which we concur, as we see these problems we have in this country on manpower needs. We might disagree on how we reach those objectives but I certainly think our objectives are the same.

Dr. **Richmond**. Thank you very much.

Mr. **Waxman**. Our next witnesses come from the schools of medicine, osteopathy, and dentistry. Representing the Association of American Medical Colleges is Dr. Edward Stemmler, dean of the University of Pennsylvania School of Medicine. Representing the schools of osteopathic medicine is Dr. Philip Pumerantz, president of the College of Osteopathic Medicine of the Pacific in California. Representing the schools of dentistry is Dr. Dale F. Roeck, the dean of the Temple University School of Dentistry in Philadelphia.

I would like to welcome you to this hearing. We have many, many witnesses, as you might imagine, who are interested in the health manpower legislation. So what we are asking each of you to do is to summarize your prepared statement, which will be made a part of the record in its entirety, in approximately 5 minutes. I understand that the staff has indicated that was our expectation. We also want to leave time for questions and answers and general theories on the economy by members of the subcommittee.

Dr. Stemmler.

STATEMENTS OF EDWARD J. STEMMLER, M.D., ON BEHALF OF ASSOCIATION OF AMERICAN MEDICAL COLLEGES, ACCOMPANIED BY JOHN SHERMAN, M.D.; PHILIP PUMERANTZ, PH. D., MEMBER, BOARD OF GOVERNORS, AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE AND ALSO ON BEHALF OF AMERICAN OSTEOPATHIC ASSOCIATION, AND AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION; AND DALE F. ROECK, D.D.S., ON BEHALF OF AMERICAN DENTAL ASSOCIATION

Dr. **Stemmler**. I am Dr. Edward J. Stemmler, dean of the University of Pennsylvania School of Medicine. Dr. Sherman and I represent the Association of American Medical Colleges. I would like first to assure you that my testimony this afternoon as well as the lengthy backup statement to be submitted for the record reflect the overwhelming consensus that prevails within the association.

Within this very hour the association's executive council reviewed and approved both drafts. The failure to provide you preprints was due to our decision to first secure this executive council approbation.

Let me summarize very briefly our positions on the financing of medical education.

Medical schools must provide the public first-class physicians through high-quality medical education.

Within the limits of available first-year places, access to medical education should be determined only by the ability of the applicants and their probable capacity to be conscientious, competent, and compassionate physicians. Adverse selection based on race, creed, color, gender, handicap, or economic status should never occur.

The cost of the system for medical education should be equitably borne by all of the beneficiaries—students, general public, and political jurisdictions and by local, State, and Federal Governments.

The schools stake their claim on Federal resources on the fact that they are engaged, perennially and to a significant degree, in public service activities that impact on the whole Nation. Therefore the Federal Government should provide a balanced portfolio of student assistance programs, offer basic support to educational institutions and make available cost reimbursement awards for the conduct of specific tasks to meet high-priority national goals and objectives.

STUDENT ASSISTANCE

In view of their future high-income potential, medical students should be expected, for the most part, to finance a substantial part of their education, by either out-of-pocket financing or through borrowing. The economically disadvantaged need support at the time they enter medical school, and their access to medical education and choice of medical career will depend on the program of scholarships for exceptionally needy students.

Student assistance programs should be needs-based, should assure availability of support throughout the period of education, and should be structured to keep debt to reasonable and manageable proportions until completion of residency training.

Service pay-back programs should not be viewed as, or used for, student assistance; loan forgiveness incentives should be explored to meet service needs.

A summary of the specific comments on the provisions of these bills is that the AAMC: Commends the retention in both of the scholarship programs for students in exceptional financial need; approves the continuation of the health professions student loan program provided in H.R. 6802 and are dismayed by the administration's proposal which not only does not extend the authority for the program but implicitly diverts enormously useful educational funds in the revolving accounts of the schools to the U.S. Treasury; and urges a melding of the modifications that these bills propose for the health education assistance loan program—a last-resort source of student assistance—to make lending attractive to banks and to make money available to students.

INSTITUTIONAL SUPPORT

Institutional support is a critical need of the schools. Committed to a myriad of educational, research, and patient care activities, all of which contribute to the improvement of the Nation's health, schools require this to respond to a host of pressing national social problems.

Without that support to integrate their many discrete activities into a more coherent, orderly and effective program or to compensate for the failure of external program sponsors, especially the Federal Government, to fully reimburse costs, they will be forced to discontinue many, if not all, of their joint efforts with the Government.

Tuitions, a theoretically available source for such funds in private but not public schools, are already staggeringly high in those institutions. Medical education is so expensive that without institutional subsidy it is beyond the economic reach of many altruistic and well-motivated students. Placing the full burden on students would effectively limit access to the profession to the affluent.

Institutional support has paid off handsomely to all parties—Government, schools, and public. For want of a relatively small investment, the present administration would break a bond with institutions whose power as agents of social change has been repeatedly demonstrated.

The AAMC regrets the failure of the administration to provide institutional support in any way, shape, or form for medical schools.

The readjustment in primary care residency levels required of schools by H.R. 6802 to be eligible for institutional awards cannot be supported because it presumes that schools have the power to influence decisions that are totally beyond their control, it is unnecessary and even self-defeating in the face of the strong trends obvious today and it is premised on a flawed concept that primary care, contrary to increasing published evidence, should be provided by only physicians who call themselves primary care specialists.

Special project grant programs complement the other mechanisms for Federal assistance to medical education. Solutions to specific societal problems can be sought through competitive cost reimbursement contracts with institutions capable of doing the job. These programs are ideal for exploiting the rich diversity represented among the schools. However, they seldom reimburse full cost and require that the schools subsidize them from limited institutional resources.

Both bills incorporate a range of special project programs. We recommend that the list be broadened and diversified and that the authorization ceilings be increased.

We do support the array of special project grants, and we would suggest that we can work with you in trying to identify areas in which there may be voids and in which we might be helpful in identifying areas of great opportunity.

We do hope that the construction authorities can be retained. There is a serious need for ambulatory teaching facilities in primary care. In addition there is a growing need to rehabilitate substantial elements of the educational plant. We are pleased to note that H.R. 6802 provides Federal loan guarantees for this purpose.

On the foreign medical graduate point, both H.R. 6800 and H.R. 6802 propose, in part, to modify the Immigration and Nationalities Act in respect to exchange visitor visas for foreign medical graduates. We support the extension in the allowable duration of stay for J-visa holders but strongly oppose the provision that would extend the VQE waiver period through 1983.

The latter change would be a grievous disservice to medicine, to medical education, to the general public and especially to the urban poor, for whose sake they are putatively being made.

We thank you and would like to work with you for the passage of a satisfactory bill.

Mr. **Waxman**. We want to welcome you, Dr. Pumerantz.

STATEMENT OF PHILIP PUMERANTZ, PH. D.

Dr. **Pumerantz**. I bring you good news. There is no rain at this point. Let me also thank you for the efforts you have made on behalf of health manpower. Your bill is the only one from the

House side that really has addressed the extention. We appreciate that.

My name is Philip Pumerantz. I am president of the College of Osteopathic Medicine of the Pacific and I am a member of the board of governors of AACOM. I want to speak on behalf of our association and the two other national associations—the AOA and the American Osteopathic Hospital Association. Together we seek an effective continuation of Federal support for health manpower education.

My remarks here will be brief and abbreviated in the interest of time but I would like to submit a more comprehensive report, which I am sure you have. [See p. 136.]

This afternoon I want to discuss briefly the concerns that are common to all health professions—namely, institutional support and student assistance. I also want to speak to some areas of particular significant to osteopathic medical education—namely, predoctoral education, faculty development and remote site ambulatory care.

I think it is a well-known fact in this country that the osteopathic profession, from its very beginning, has been committed to providing primary care and community-based medicine and has had a tremendous record of redressing geographic and specialty imbalances and doctor shortages.

For example, at the present time there are approximately 17,000 D.O.'s in practice in this country, and about 90 percent are engaged in primary care. They are using the ambulatory care approach, which is efficient and which is cost effective.

Without question, this profession has an enviable record of responding to national health care needs and even before these needs became Federal policy. Indeed the public has come to expect timely, quality care in the osteopathic tradition.

You will be interested to learn—I am sure you are aware of this—the fact that in California the Office of Statewide Health Planning several months ago confirmed the fact that there is a significant shortage. The report said, in part, that the State needs more general practitioners to treat the common cold rather than more specialists.

It is ironic that the State is facing a surplus of physicians while at the same time facing a lack of general practitioners. And it is to this very purpose that our college in Pomona and the other osteopathic medical colleges in the country are dedicated. In fact, our students are being trained from the very start of their medical school education to become primary care physicians.

The growth of osteopathic education in recent years, we feel, is eloquent testimony to the role this profession has in health care. For example, in the last 10 years the number of our colleges has doubled, going from 7 to 14 at the present time, and there is one more on the horizon next year sprouting up in Florida.

Our enrollment has more than doubled. Presently the number of students enrolled in all of the 14 colleges is 4,284. The number of women and minorities enrolled is rising steadily. By the time our present freshman class graduates, the total number of D.O.'s will have risen 25 percent, with the bulk of those in primary care service.

These achievements have enabled this profession to help confront the problem of physician shortages and maldistribution.

At this point let me point out that these gains were made possible in large measure through Federal support, specifically Public Law 94-484; yet let me also point out that it is this very factor which was most responsible in helping us to respond to the national health care priorities, now under attack by the administration and certain Members of the Congress. I refer, of course, to the institutional support.

Mr. Chairman, if institutional support is terminated, we believe that the health professions education, as we know it now, will be severely affected. Therefore we are obviously delighted that H.R. 6802 proposes to continue current institutional support.

One of the most critical aspects of institutional support has been the federally supported student assistance programs. These programs have been successful in making doctors available in needy areas and they have also made sure that being rich is not the criteria for getting into medical schools. Without student support, loan debts, and health care costs would become even worse.

Let me take a moment to outline some of the areas that we are interested in supporting. First of all, we favor a mix of scholarship, subsidized loan, and conventional loan programs with a strong emphasis on service-related forgiveness options.

For example, we know that the NHCS scholarship program was very effective in channeling students into geographic and specialty shortage areas and minimizing economic discrimination.

Also, we are delighted with the continuation authority for the Health Professions Student Loan program. Incidentally this is at a relatively low default rate, about 2 percent. In other words, the proposal to extend the HEAL program is fine so long as a graduated repayment schedule is included to offset the high interest rates.

But we want to oppose the limitation of deferral periods to 3 years following graduation since this discriminates against the osteopathic educational model by failing to consider the osteopathic rotating internship which osteopathic graduates must have.

With respect to the medicaid-medicare reimbursement reforms proposed in H.R. 6802, it is good to see legislative initiatives in the need to support primary care residency programs.

Another point I want to make—this deals with the uniqueness of osteopathic education, of osteopathic predoctoral education, which is a level, by the way, that has never received adequate Federal support—it is interesting to note that D.O.'s receive a major portion of their training as undergraduates.

For this reason, the residency and training model on which Public Law 94-484 and H.R. 6802 are based is of little relevance to our curriculum. Not only does this approach overlook a basic strength of our educational model; it effectively discriminates against our colleges in competing with allopathic colleges for support, in a sense penalizing our successes with the primary care training model.

It is on this predoctoral level of osteopathic medical education that the greatest potential exists to attract and educate significant numbers of students in primary care, and therefore it seems to me that the flow of funds to this area should be a matter of Federal priority.

Let me summarize by just suggesting that the 14 colleges of osteopathic medicine are collectively a national resource providing the sole focus of instruction in osteopathic principles and practices. We believe that the time has come for Congress to recognize the unique contribution of osteopathic medical education by designing legislation which will allow our colleges to move toward full realization of their role as a separate and equal partner in the federally supported manpower training programs.

Our colleges are sensitive to the continuing need to train primary care professionals and they are singularly qualified to meet this need.

We welcome this opportunity to meet with you as individuals directly involved in shaping the national health policy, and we will be happy to answer any questions. Thank you, Mr. Chairman.

[Testimony resumes on p. 143.]

[Dr. Pumerantz' prepared statement follows:]

Testimony of the

AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE

Mr. Chairman, I am Dr. Philip Pumerantz, a member of the AACOM Board of Governors and President of the College of Osteopathic Medicine of the Pacific. I am speaking today on behalf of the Association, and of the two other national osteopathic professional organizations, the American Osteopathic Association and the American Osteopathic Hospital Association, which join us in seeking a viable and effective continuation of federal support for health manpower education. My remarks today are abbreviated in the interest of time; I would, however, like to submit a more comprehensive statement for the record.

The issues I want to address this morning pertain to concerns common to all the health professions relative to institutional support and student assistance, as well as matters of particular significance to osteopathic medical education in the areas of predoctoral education, faculty development, and remote-site ambulatory care training.

Commitment to primary care and to the redress of geographical and specialty imbalances is no stranger to osteopathic medical education and practice. Osteopathic medicine has from its beginnings emphasized the preparation of primary care practitioners for community-based service: of the more than 17,000 osteopathic physicians in the United States today, more than 91 percent are engaged in the delivery of primary care. Moreover, osteopathic physicians have tended to settle in health manpower shortage areas: 67 percent of all practitioners live and work in the nation's largest and smallest communities, over half of these in communities of 50,000 or fewer. The profession's emphasis on ambulatory care has over the years perpetuated a model of efficiency and cost-effectiveness. In short, osteopathic medicine has had a proven record of responsiveness to national health care needs even before they were articulated in terms of federal policy; and over the years we have developed considerable expertise in assuring all Americans access to timely, pertinent, quality primary health care.

Today the osteopathic profession is on the threshold of unparallelled expansion. During the 1970's the number of colleges of osteopathic medicine doubled (from 7 to 14), and enrollments more than doubled. The numbers of women and minorities entering the profession are greater than before, and rising steadily. By the time the current freshman class graduates, the total number of osteopathic physicians will have risen by nearly 25 percent, the bulk of whom will be primary care practitioners. Many of these gains can be directly attributed to the impact of P.L. 94-484. Lacking the impetus of federal support, it is doubtful that our colleges could have undertaken the dramatic increases in student enrollment and the development and expansion of facilities required to address the acute geographical and specialty maldistribution problems identified by Congress. Yet is is precisely that factor most immediately responsible for encouraging our successful response to national health priorities which is now under attack by the Administration and in certain quarters of Congress: I refer, of course, to institutional support.

Mr. Chairman, the effect of a massive and abrupt disruption of general institutional support on the quality of educational programming and institutional stability cannot be overstated: without question, the failure to continue adequate core funding will spell the death of health professions education as we know it. We are thus highly gratified that H.R. 6802 proposes to continue current institutional support authorities, thereby recognizing the crucial character of such funding as a major building block of health manpower development.

Federally-supported student assistance programs have been highly successful mechanisms for assuring the availability of an adequate practitioner supply, while permitting students to enter the health manpower work force regardless of economic status. Without such support student debt loads - and with them, health care costs - will skyrocket, and economics rather than talent will determine the composition of the student pool, to the detriment of both quality and equality of opportunity.

We advocate a pluralistic mix of scholarship, subsidized loan, and conventional loan programs, with a strong emphasis on service-related forgiveness options. Initiatives such as the NHSC scholarship program have been extremely effective methods of channeling students into geographical and specialty shortage areas while minimizing economic discrimination. Such mechanisms, especially if sustained by the broad spectrum of support services for practitioners in underserved areas proposed in both Senate bills, should prove highly effective in attracting and retaining health care personnel in these areas.

We are particularly pleased to see continuation authority for the Health Professions Student Loan Program. This program, the only direct loan program targeted specifically at health professions students at an affordable interest rate, has just begun to recapitalize on the basis of loan repayments, and has been experiencing an unusually low (less than 2 percent) default rate. The proposal to extend the HEAL program is acceptable provided that a graduated repayment schedule is included to offset the high market interest rate at which the program is capitallized.

We also endorse continuation of interest subsidies and deferrals, particularly for students undertaking postdoctoral training in areas of national need. However, we actively oppose the limitation of deferral periods to three years following graduation, a practice which discriminates against the osteopathic educational model by failing to take into account the osteopathic rotating internship which must be completed by all students in addition to residency training.

With respect to the Medicare/Medicaid reimbursement reforms proposed in H.R. 6802, we are pleased to observe tangible legislative recognition of the need to support primary care residency training at a level consistent with actual costs and with federal ambulatory care initiatives in other areas. Reimbursement of outpatient services at a rate substantially lower than for inpatient care has been a potent disincentive to ambulatory treatment as a therapeutic option consistent with the maintenance of institutional solvency. Inevitably, these considerations influence training patterns as well, and medical students are taught to view the inpatient model as the predominant orientation of their professional practice.

If the federal government is truly committed to lowering health care expenditures, adequate reimbursement must be provided for primary care services, thereby permitting teaching hospitals and the students they train to absorb both the lessons and the benefits of cost containment.

Let me now turn to several aspects of the ostepathic educational model which we believe must receive legislative attention if the profession is to remain maximally responsive to national health care priorities.

Foremost among these is osteopathic medicine's unique emphasis on predoctoral education, a level of training which has never received adequate federal support. Osteopathic physicians receive the major portion of their primary care training as undergraduates; for this reason the residency training model on which P.L. 94-484 and H.R. 6802 are based bear little relevance to our curriculum. Not only does this approach overlook the primary strength of the educational model, it effectively discriminates against our colleges in competing with allopathic institutions for support by penalizing our schools for past successes in training primary care physicians under an alternate educational model. The flow of funds to the predoctoral level of osteopathic medical education should be a matter of federal priority, for it is here that the greatest potential exists to attract and educate significant numbers of students in primary care practice. The proposal under Section 794(c) to direct a portion of preventive medicine funds to predoctoral training is a step in the right direction, and should be considerably broadened to include all areas of primary care education. We similarly endorse the proposal to continue support to the ostoepathic internship, the capstone of osteopathic family medicine training.

A second area in which we are pleased to observe change is that of faculty development and enrichment. The primary care faculty development component of Section 218 is especially welcome, for in the past, due in large measure to its linkage with primary care residencies under a single training authority, faculty development in this area has been virtually ignored. As for facutly enrichment, time and site limitations have acted as disincentives to participation in continuing medical education activities, praticularly by clinician faculty members with heavy practice commitments. We are therefore gratified to note a resurgence of interest in faculty development in your bill, and we hope to see these provisions included in final legislation.

A third area in which the colleges of osteopathic medicine have successfully pioneered new avenues of clinical education is that of remote site ambulatory care training. While we are pleased to note continuation of the remote site requirment under Section 770, we are disappointed that H.R. 6802 fails to include support for clinical training, an approach consistent with the preceptorship and community-based training components of osteopathic medical education as well as the profession's traditional emphasis on service in physician shortage areas. One factor influencing our marked success in attracting and retaining practitioners in underserved communities has been the exposure of students early and repeatedly during their clinical training to practice in remote-site ambulatory settings. Regrettably, until now relatively little federal support has been forthcoming for this training modality. While remote-site training is unquestionably a cost-effective activity both in terms of providing direct services in shortage areas and in developing practitioners interested in making a long-term career commitment to this type of practice, it is an expensive process which will require federal assistance if it is to continue and grow.

The fourteen colleges of osteopathic medicine are collectively a national resource, providing the sole focus of instruction in osteopathic principles and practice. We firmly believe that the time has come for Congress to recognize the unique contribution osteopathic medical education has made by designing legislation which will allow our colleges to move toward full realization of their role as a separate and equal partner in federally-supported health manpower training programs. Our colleges are sensitive to the continuing need to train primary care professionals, and are signularly qualified to meet that need. We welcome this opportunity to meet with those individuals directly involved in shaping national health manpower policy, and we will be happy to answer any questions relative to our testimony.

Mr. WAXMAN. Thank you. I would like to call on Dr. Dale Roeck before addressing questions to you.

STATEMENT OF DALE F. ROECK, D.D.S.

Dr. ROECK. Thank you, Mr. Chairman and members of the subcommittee. I am Dr. Dale F. Roeck and I am dean of the Temple University School of Dentistry. I am appearing today on behalf of the American Dental Association.

The association has prepared a detailed statement of its views on health manpower, which we wish to submit for the record. [See p. 146.]

In the time available this afternoon I would like to briefly discuss several issues of particular importance to dentistry which we believe should be considered in the development of any new health manpower law.

The dental education system rests upon an extremely fragile economic base. Ten years ago the average annual cost to train a dental student amounted to about $10,000. Today the yearly educational cost is estimated to exceed $21,000, one of the highest of the health professions.

Each source of public and private revenue which our schools are able to generate represents a critical element within this financial matrix. For most dental schools, a viable program of Federal assistance is not simply desirable; it is essential. Schools of dentistry are currently receiving over $21 million in annual institutional, or capitation, grants. These funds sustain the basic instructional activities of our educational system with an average of more than 56 percent of this support utilized for faculty and staff salaries. At some schools this figure exceeds 80 percent.

The association is concerned that, in the absence of adequate Federal assistance, a large number of dental schools will be forced to raise tuition to unacceptably high levels. The consequence of this action is already evident in the precipitous decline in dental school applicants which has occurred since 1974.

Between the academic years 1973–74 and 1979–80 the average tuition rate at all dental schools increased by 126 percent. During the same period the number of individuals applying to dental schools fell by 26 percent.

We believe that it is also necessary to recognize the link which exists between a financially sound dental education system and improved dental care delivery. This subcommittee is aware of the large-scale enrollment increases which have been achieved since the inception of direct Federal support to the health professions in 1963.

It is frequently overlooked, however, that the greatly expanded dental education system is also a significantly improved system. The fiscal stability and financial incentives which previously were assured under the health manpower statutes have enabled schools of dentistry to improve faculty-student ratios, replace outmoded teaching facilities and, of particular importance, launch new programs emphasizing: dental disease prevention; increased productivity; primary care; quality assurance and peer review; and the dental care needs of underserved populations, the elderly, handicapped, and other special groups.

These programs are, in the opinion of the American Dental Association, both effective and relevant to the national issues which have been identified by Congress and the Executive. Similarly the ability of our dental schools to continue to respond to these objectives is, we believe, unquestionably tied to an adequate and predictable level of direct Federal assistance.

If it is determined that such support is to be accompanied by prudent requirements, we must insist that these conditions be appropriate to dentistry and compatible with the resources of the dental schools.

There has been a perception in the past that problems which may exist in one delivery system are present in all disciplines. For dentistry, this has occasionally led to the enactment of requirements for Federal grants which have been inappropriate and potentially counterproductive.

The association's record statement contains examples of projects which the dental schools could establish and maintain within the framework of an institutional support grant authority.

The ADA believes that an improved program of student assistance must be accorded a high priority in any renewal of the health manpower law. Such a program should be responsive to the needs of the student while in school rather than on a perception of income earned in later professional life. The most recent information available to the association indicates that financial aid is required by the majority of the more than 22,000 dental students for completion of their education. It is estimated that for the 1978–79 academic year the average cost to the dental student for tuition, fees, instruments, and living expenses is above $12,000.

The association has noted earlier the negative effect of expanding educational expenses on applicants to dental schools. We also foresee the possibility that increasing student indebtedness will ultimately translate into higher fees and the establishment of practices in economically attractive areas, thus contributing to the twin problems of rising health care costs and geographic maldistribution of health personnel. The association's recommendations for student assistance are outlined in our record statement.

Careful consideration should be given to the period of authorization for a new health manpower law. Over the past 18 years, each successive renewal of the manpower statutes has produced new "national priorities," revised levels of Federal assistance and, in some instances, an abrupt termination of funding for ongoing programs. This experience prompts the association to recommend that Congress evaluate the feasibility of a 5-year authorization for these programs of support. Continuity and predictability of revenues is as important to dental education as it is for any other large and complex enterprise. If this concept is carried through in new legislation, a 5-year authority would provide dental schools with an initial 12 months in which to evaluate and qualify for assistance, and 4 years in which they can assume a measure of stability in the requirements for such support.

The final issue on which I wish to comment is the National Health Service Corps. As our record statement will indicate, the association is particularly concerned over the cost, program philosophy, and projected size of the Corps.

The dental profession recognizes a Federal role in efforts to improve access to care. This recognition does not, however, include the provision of dental services in those areas where care is available from the private sector.

Briefly stated, the association objects to: the number of Corps dental personnel who have been placed in areas of marginal need; the shift in emphasis away from solo practice settings to the assignment of Corps dentists to fixed-site health centers: and the failure to provide a meaningful role for local dental societies in the designation of shortage areas and the placement of Corps dental personnel.

The ADA believes that the National Health Service Corps was enacted as an interim measure, one that would serve as a catalyst for the development of private practices in shortage areas. Unfortunately this concept has been largely abandoned as the Department has moved to create what appears to be a permanent Federal health care delivery system.

Mr. Chairman, this concludes my remarks. I would be happy to attempt to answer any questions which the subcommittee may have.

[Testimony resumes on p. 178.]

[Dr. Roeck's prepared statement and attachments follow:]

Record Statement of
The American Dental Association
on
Health Manpower Legislation
Before the
Subcommittee on Health and the Environment
Committee on Interstate and Foreign Commerce
U.S. House of Representatives

March 20, 1980

Mr. Chairman and Members of the Subcommittee:

The American Dental Association has prepared a lengthy series of recommendations on the health manpower legislative proposals which are currently pending in Congress. These comments are contained in the body of this statement and in the supplementary documents which are appended. Before addressing the specifics of these bills, the Association wishes to first discuss several issues of particular importance to dentistry which it believes should be considered in the development of any new health manpower law.

-- The dental education system rests upon an extremely fragile economic base. Ten years ago the average, annual cost to train a dental student amounted to about $10,000. Today the yearly educational cost is estimated to exceed $21,000 - one of the highest of the health professions. Each source of public and private revenue which our schools are able to generate represents a critical element within this financial matrix. For most dental schools, a viable program of federal assistance is not simply desirable, it is essential. Schools of dentistry are currently receiving over $21 million in annual institutional (capitation) grants. These funds sustain the basic instructional activities of our educational system with an average of more than 56 percent of this support utilized for faculty and staff salaries. At some schools this figure exceeds 80 percent.

-- The Association is concerned that in the absence of adequate federal assistance, a large number of dental schools will be forced to raise tuition to unacceptably high levels. The consequence of this action is already evident in the precipitous decline in dental school applicants which has occurred since 1974. Between the academic years 1973-74 and 1979-80 the average tuition rate at all dental schools increased by 126 percent. During this same period the number of individuals applying to dental school fell by 26 percent. (See attached analysis)

-- The relationship between increasing student indebtedness and future practice patterns must also be examined. Data obtained by the American Association of Dental Schools in separate surveys of 1978 and 1979 indicates that an increasing number of graduating seniors are deferring the establishment of self-employed private practices and are instead seeking to associate with existing practices or obtain salaried positions in the military, Veterans Administration or U.S. Public Health Service. This concentration of dental resources produces an excess capacity in certain segments of the delivery system while aggravating the problems of geographic maldistribution in areas without adequate access to dental care. We also foresee the possibility that increased indebtedness will ultimately translate into higher dental fees and the establishment of practices in economically attractive areas, thus contributing to the twin problems of rising health care costs and geographic maldistribution of health personnel.

-- We believe it is also necessary to recognize the link which exists between a financially sound dental education system and improved dental care delivery. This Subcommittee is aware of the large scale enrollment increases which have been achieved since the inception of direct federal support to the health professions in 1963. It is frequently overlooked, however, that the greatly expanded dental education system is also a significantly improved system. The fiscal stability and financial incentives which previously were assured under the health manpower statutes have enabled schools of dentistry to improve faculty-student ratios, replace outmoded teaching facilities and, of particular importance, launch new programs emphasizing:

- dental disease prevention
- increased productivity
- primary care
- quality assurance and peer review, and
- the dental care needs of underserved populations, the elderly, handicapped and other special groups.

These programs are, in the opinion of the American Dental Association, both effective and relevant to the national issues which have been identified by Congress and the Executive. Similarly the ability of our dental schools to continue to respond to these objectives is, we believe, unquestionably tied to an adequate and predictable level of direct federal assistance.

-- If it is determined that such support is to be accompanied by prudent requirements, we must insist that these conditions be appropriate to dentistry and compatible with the resources of the dental schools. There has been a perception in the past that problems which may exist in one delivery system are present in all disciplines. For dentistry, this has occasionally led to the enactment of requirements for federal grants which have been inappropriate and potentially counterproductive. Recognition that dentistry and dental education is separate and unique from the other health professions is therefore a necessary beginning in the development of any new manpower law. A principal element which should accord an independent status for dentistry is the national resource function of the dental schools. In contrast to medical education with 125 schools, dentistry has only 60 degree granting institutions. More importantly, 17 States do not have a dental school. Consideration should also be given to the high cost to train a dental student, the absence of any significant private or philanthropic assistance for dental education, limited federal and other third party reimbursements for dental school clinical services and, the physical constraints which are inherently present in dental instructional facilities.

-- Careful consideration should be given to the period of authorization for a new health manpower law. Over the past 18 years, each successive renewal of the manpower statutes has produced new "national priorities", revised levels of federal assistance and, in some instances, an abrupt termination of funding for on-going programs. This experience prompts the Association to recommend that Congress evaluate the feasibility of a five year authorization for these programs of support. Continuity and predictability of revenues is as important to dental education as it is for any other large and complex enterprise. If this concept is carried through in new legislation, a five year authority would provide dental schools with an initial 12 months in which to evaluate and qualify for assistance, and four years in which they can assume a measure of stability in the requirements for such support.

The remainder of the Association's statement will address, within the context of selected programs, the health manpower bills which have been introduced in Congress to date.

Institutional Support

The legislation to be introduced on behalf of the Administration and the measure (S.2144) sponsored by Senator Richard Schweiker, propose to terminate the authority for capitation grants. Although the ADA believes that the capitation program, as presently structured, must be substantially modified, it nevertheless remains committed to the concept of federal institutional support to the health professions schools. The Administration contends that earlier health manpower problems such as a shortage of health personnel have largely been resolved and that others, including a geographic maldistribution of practitioners, can best be addressed through the National Health Service Corps. As a consequence, it is argued, the capitation grant program has outlived its utility and should be eliminated.

The ADA concurs that further mandatory enrollment increases are unnecessary. There is every indication that the dental care delivery system has sufficient flexibility to meet present and projected demand for services. As we have attempted to demonstrate, however, any abrupt decision to withdraw federal institutional support would have a profound, negative effect on efforts to improve access to care.

The proposed elimination of institutional assistance in S.2144 is partially off-set by an expanded program of highly targeted Special Project grants. Our objection to this approach does not stem from the goals which are expressed in these projects, but rather from the inability of this funding mechanism to ensure an adequate and predictable level of federal support. As noted earlier, dental schools are currently receiving over $21 million in annual capitation grants. Because a majority of the schools would be unable to generate replacement funds, a benchmark by which we must evaluate any alternative grant program is the extent to which it will provide a level of assistance that is at least equal to that presently received by schools of dentistry. The Special Project Grant program as proposed in S.2144 fails to meet this standard.

As we understand the provisions of S.2144 (Part C), it will be necessary for dental and other health professions schools and entities to compete for a limited amount of Special Project Grant funds allocated among a number of discreet activities. The immediate dilemma which would result from this concept is the uncertainty as to the amount, if any, which an applicant institution would actually receive on a year to year basis. This problem is further compounded by the fact that the total sums to be authorized and available under both Special and Supplemental Project Grants are considerably below the levels of assistance currently provided under P.L. 94-484. Of the ten categories of project grants for which dental schools would be eligible to compete, two are presently funded under the existing Special Project Grant authorities and cannot, therefore, be considered as a partial replacement for capitation grants. A third, Remote Site Training, is a requirement of capitation grants and 38 dental schools have in fact exercised this option. A total of over $15 million is currently awarded to these institutions for the support of remote site training whereas only $5.5 million is authorized in fiscal 1981 under S.2144 for this purpose for all health professions schools. The remaining categories (7) of Project grant assistance for which dental schools may apply, in competition with medical and other professional and allied health schools, have a combined fiscal year authorization of less than $40 million - again underscoring the inadequacy of Special Project grants as a meaningful replacement for institutional support.

Section 730 of the bill would authorize a 20 percent increase in the level of a school's Special Project grant(s) if certain conditions are met. There are three drawbacks to this approach. An initial problem occurs because the sums which an institution could receive through these "supplemental" awards are determined by applying a factor of one-fifth to the amount of a school's Special Project award(s) rather than on the basis of what it will cost to meet the requirements outlined in Section 731. Secondly, the uncertainties of support which are associated with Special Project grants, described earlier, are carried forward in the funding mechanism for the proposed supplemental awards. In other words, a school of dentistry would agree, presumably at the time of application submission, to meet the conditions of Section 731 in return for an additional award to be calculated by applying 20 percent to a then unknown level of Special Project grant assistance. And, finally, given the limited amount of funds to be authorized for Special Project grants, many schools may simply conclude that an increase of 20 percent does not justify the added expense which would be incurred in meeting the assurances called for in Section 731.

The measure, S.2375, sponsored by Senator Edward Kennedy would replace capitation assistance with a new National Priority Incentive Grant Program. As we understand the proposal, dental and other health professions schools would be entitled to an annual base level of support (calculated) initially at $500 per student) with additional sums to be added in return for meeting specified objectives. Conversely, the bill provides for decreases in the amount of such support if certain negative factors are evidenced in a school's teaching program. There is a degree of merit in this approach, both in the fiscal stability which would result from annual entitlement grants and in the flexibility that allows dental schools to respond to a series of national goals in return for additional financial assistance. Unfortunately a number of the incentives outlined in Section 772(e)(21) of the bill are either unrealistic or inappropriate for the dental education system.

Two of the provisions of that section, establishing a requirement for a 15 and 40 percent first-year enrollment, respectively, of minority and female students are simply not achievable for most dental schools. Inadequate programs of student aid, increasing tuition and other educational expenses, and a declining applicant pool are largely responsible for this situation. Even if these barriers were to be immediately addressed in a new manpower law - as the Association is urging - the lag time before an appreciable number of minority and female applicants seek admission to dental schools is still several years away. A more positive approach to this issue would be an incentive to encourage and assist dental schools to establish programs which are designed to identify, recruit and consult minorities and females to pursue a career in dentistry. A third incentive to be met (772(e)(2)(c)), regarding primary care and public health, is not only unnecessary for dentistry, it is also potentially counterproductive. Because the dental care delivery system has, until recently, been allowed to function with a minimum of federal intervention, the profession has achieved a very positive ratio of general practitioners to specialists. In this instance a 9 to 1 distribution. To arbitrarily establish this ratio as a national standard for all dental schools fails, initially, to recognize that an overwhelming majority of the advanced training in general dentistry and public health occurs in hospitals and other settings which are not affiliated with dental schools. More importantly, this requirement works to the disadvantage of those developing schools which will serve areas of the Nation with an unusually small percentage of dental specialists. To cite an example, one new dental school is located in a State in which the total supply of active specialists numbers less than 70. What purpose then would be served by encouraging such institutions to emphasize primary care when there may be a demonstrated need for dentists who have received advanced training in specialized skills. The Association believes this issue can more properly be addressed within the provisions of Section 786(b) of the current law which provides grants and other assistance for dental general practice residency training programs.

A fourth incentive of S.2375 calls for (A) a first-year dental school enrollment in which 10 percent of the students are from health manpower shortage areas designated under Section 332 of the PHS Act, and (B) the establishment of off-site training programs as required in the present law. With respect to the first condition, it should be recognized that only 861 areas have been designated under Section 332 as dentally underserved. Thus the goal of 10 percent first year enrollment is unrealistically high. At the same time however there are presently 11 States without a dental school. Historically these States have relied upon private dental schools to provide training opportunities for their residents. As these private institutions have been forced to obtain State assistance in one form or another, the percentage of out-of-state enrollment has declined significantly. The extent of this shift in admissions raises a serious concern as to the future availability of student places for residents of states without dental education programs. In view of these factors we would recommend that the proposed requirement be lowered to 5 percent and applied to a combined total of students from both underserved areas (Section 332) and states without a dental school.

Because of the cost of establishing and maintaining an off-site training program, the Association believes that this second condition should be separated from paragraph (D) and made an independent incentive.

The ADA endorses the incentive outlined in paragraph E. We would also recommend that additional incentives be added to Section 772(e)(2) which provide experiences in the provision of care to special population groups, i.e. handicapped, residents of nursing homes, and institutionalized patients. To ensure an equitable distribution of the limited funds which are to be authorized (Section 774(c)) for the proposed National Priority Incentive Grant program, the Association further recommends that participating dental schools be limited to a maximum of five incentives per institution.

Section 772(e)(3) of the bill proposes two disincentives which, if applied, would reduce the sums available to a dental school under this program. The Association recognizes that one of the penalty provisions, relating to allowable tuition increases, is a requirement of current law. We are not aware of any situation in which this limitation has adversely affected a dental school. For many of our private schools, however, a decline in federal funding of institutional support grants would leave no alternative to an increase in tuition levels. The recent record of appropriations for health manpower programs provides ample justification for this concern. We would also note that for some institutions, decisions regarding tuition are not a function of the individual professional schools but of the university administration or a higher authority (as in the case of certain state education systems). The American Dental Association certainly endorses efforts to restrain tuition increases. In our opinion, however, this should more appropriately occur at a level where the most accurate assessment can be made of a dental school's finances. Accordingly we recommend the elimination of this provision of S.2375.

The Association strongly supports the intent of the second disincentive relating to enrollment increases for schools of dentistry.

The final bill on which the Association will comment, as it relates to institutional support, is H.R. 6802. With the exception of certain modifications, this measure is for the most part a three year extension of the current authorities. Capitation grants for dental schools would, as we understand the bill, be continued with the same unnecessary and burdensome requirements that exist today. We cannot accept this proposal and therefore urge its rejection.

Student Assistance

The most recent information available to the Association indicates that a sizeable majority of the more than 22,000 dental students require financial assistance to complete their education. It is reasonable to assume that both the absolute number of students seeking aid, as well as the level of assistance required, will grow in proportion to the additional increases in tuition which can be expected to occur in the next few years. As noted earlier, the average tuition increase at all dental schools has exceeded 126 percent over the past five years. The total annual cost to the dental student (tuition, fees, instruments and living) presently averages about $12,000. In the face of this financial need, dental students must rely upon a confusing, inadequate and at times conflicting array of federal assistance programs.

In the opinion of the ADA, a comprehensive and fiscally viable program of health professions student aid must be accorded priority consideration in any renewal of the health manpower law. Such a program should be responsive to the needs of the participant while in school rather than on a perception of high income in later professional life. Basic elements of this authority should include:

- An extension of the Health Professions Student Loan program with an increased federal capitalization. Direct student loans which are awarded under this authority should be targeted to "financially needy" students with an overall ceiling on allowable student indebtedness;
- A new federally insured/guaranteed loan authority for health professions students as a replacement for the existing HEAL program. Interest subsidies should be available, initially to the borrower while in training, and subsequently to the lender, in order to reduce the total cost of the loan while still generating participation from the private capital lending market; and
- A two year program of scholarships for minority and disadvantaged students.

The position of the Administration on this issue is one in which students are expected to assume an increasingly higher percentage of their educational costs. Little if any consideration has apparently been given to the effect of this policy on the applicant pool or the practice characteristics of future graduates. Federally insured loans are offered by the Administration as the principal mechanism for health professions students to finance their education. The ADA believes that this program (HEAL), as presently authorized, is so completely inadequate and unacceptable that it should not be considered as a viable student assistance program - even as a supplemental source of aid. To propose, as we understand the Administration has, that the present 13 percent interest ceiling be lifted on insured loans is, to say the least, astounding. The effect of an 18 to 20 percent interest rate on the health professions educational system should be quickly apparent.

The Administration has indicated that National Health Service Corps scholarships will provide a measure of financial assistance for dental and other health professions students. We believe there is a fundamental contradiction in the Administration's approach to this issue. Corps scholarships are advocated at one level of HEW as a mechanism to address the problem of access to care. This contrasts with the position of another arm of the Department which suggests that these scholarships represent a student assistance program. We respectfully submit that it cannot serve both objectives. The dilemma which results from this duality is readily apparent when the following statistics are considered. It is estimated that the 1979-80 entering class of the 60 dental schools is in excess of 6,400 students, with a total dental school enrollment of approximately 22,000. According to the Department, approximately 185 new NHSC scholarships are available for dentistry this academic year. As should be obvious, this number of dental corps scholarships is woefully inadequate if the NHSC program is viewed as a student aid mechanism. Conversely, if the number of Corps scholarships allocated for dentistry were made equal to the demonstrated financial needs of the entire dental student body, the number of graduates obligated to serve in an underserved area would be far in excess of the requirements of the National Health

Service Corps program. In summary, the Association strongly recommends that the Department administer the National Health Service Corps as it was originally intended; namely as a temporary alternative until more permanent solutions can be found to remedy the problems of access to care. The actual number of Corps scholarships which are provided to dentistry should, in turn, reflect the present and projected need for dental personnel in documented shortage areas. Student aid should more properly be addressed within the context of direct loans, an improved guaranteed loan program, loan repayments, and scholarships for minority and other disadvantaged students.

Two measures dealing with health professions student assistance have been introduced by Senator Richard Schweiker, S.1642 and S.2144. The ADA would caution against a reliance upon a single mechanism for student assistance as is proposed in S.2144. Although the bill has considerable merit in providing for insured student loans with in-training interest subsidy and loan forgiveness for shortage area service, the advantage of S.1642 is the decision to improve the existing, complimentary authorities for direct student loans, HEAL, and Exceptional Financial Need Scholarships. Each of these programs is designed to meet the particular needs of different segments of our student population. The fact that certain authorities, such as HEAL, have been found lacking can be remedied through interest subsidies and other improvements which are contained in S.1642. Direct loans (HPSLS) have been an effective student aid approach since the inception of federal health manpower support in 1963. Within a few years the individual school loan funds have the potential to become self-sustaining. Federal capital contributions would then become unnecessary, thus realizing a major cost saving to the taxpayer. Exceptional Financial Need Scholarships should also be continued and indeed made available to needy students for at least two years. For students from disadvantaged backgrounds, the expense of a dental education and subsequent establishment of a practice requires federal support that is beyond direct or insured loans. Scholarship assistance in the form presently authorized is, in our opinion, the most equitable and effective mechanism.

The measure, S.2375, proposes an ambitious program of "need-based, campus-oriented loans" for the health professions. We believe there are several major defects in this concept. An unacceptably high cost in the initial years of operation will, in our opinion, have the unintended effect of placing severe financial pressure on other health manpower programs. The Association also questions the rationale for adding a service commitment to this loan program in view of the proposed extension and expansion of National Health Service Corps Scholarships, as well as the continuation in S.2375 of the loan repayment for shortage area service program. These latter two authorities already provide an ample pool of graduates for service in underserved communities. The creation of yet a third source of obligated students will have the unavoidable consequence of placing large numbers of graduates in areas which have at best a marginal need for additional dental practitioners.

H.R. 6802 provides, with some modification, an extension of the student aid programs presently authorized under P.L. 94-484. As the

Association indicated earlier, there is considerable merit in expanding and improving the current assistance programs. In this case, we recommend that the direct (HPSL) loan authority serve as the principal mechanism for financial support. This would require a substantial increase in the proposed levels of expenditures over that contained in Section 206 of the bill. With respect to federally insured loans (HEAL), there is an urgent need to enact an interest subsidy provision if this program is to be of any value. We do not regard the proposed amendment in H.R. 6802, deferring interest payments while in training, as a meaningful improvement. Indeed this change may only serve to compound the problem of indebtedness following graduation. Two changes are required in Section 207 extending the authority for Exceptional Financial Need Scholarships. Under current law, these scholarships are limited to first-year students only. One year of assistance for students from disadvantaged backgrounds will accomplish little to increase minority representation in the health profession. The Association therefore recommends that a minimum of two years of support be authorized for scholarship recipients. Similarly, the proposed authorization levels in this section must be raised to more realistic levels if the program is to have any significant impact.

Dental Project Grants

The existing law, as well as the major health manpower bills which have been introduced, provide grants and contract support for a number of dental and dentally related demonstration type projects. These programs include interdisciplinary training, TEAM, expanded function dental auxiliary training, and others. Because of the fiscal constraints that will undoubtedly influence decisions regarding a new health manpower law, the Association recommends that the authority for these activities be terminated with the funds redirected to support an improved program of institutional support to the schools. This will, initially, ensure a more equitable distribution of federal assistance. Dental schools which elect to participate in a new institutional support program would then have the option to continue or phase-out these demonstration projects as circumstances dictate.

Dental General Practice Residencies

Section 786 of the Public Health Service Act requires that not less than 10 percent of the amounts appropriated in each fiscal year for grants to Family Medicine and General Practice Dentistry shall be made available for dental residency training. These programs have been particularly effective in providing the future general practitioner with the skills and experiences necessary for the provision of comprehensive, primary dental care. For reasons which we fail to understand, the Administration is once again requesting the elimination of funds for this important program. Such action is particularly surprising in view of the Administration's stated emphasis on the need to increase the number of primary care practitioners. The Association accordingly recommends a continuation of support for Section 786.

National Health Service Corps

The American Dental Association has a long standing record of support for programs to improve access to dental care for underserved and other special population groups. Almost thirty years ago the Association adopted policy urging its constituent societies to survey the dental needs of these populations, develop demonstration projects which address these needs, and implement broad-based efforts to reduce or eliminate barriers to comprehensive dental care.

More recently, the 1979 ADA House of Delegates approved a landmark report titled, "Prevention and Control of Dental Disease Through Improved Access to Comprehensive Care". The report contains a series of 32 significant recommendations which, we believe, can serve as a national strategy for bringing all citizens into the mainstream of the dental care delivery system. [ENCLOSURE No. 1] Of particular importance is the decision to focus existing resources of the Association on five population segments: (1) the poor and working poor, (2) the elderly, (3) the underserved and remote-area residents, (4) the handicapped, institutionalized and homebound, and (5) the worker without dental prepayment insurance.

Fundamental to the thrust of the "access" program is the concept that improved oral health of our citizens requires a shared responsibility to be borne cooperatively by the dental profession, government at all levels, the private sector and the individual. In recognition of an appropriate federal role in achieving these objectives, the Association is presently endorsing separate legislation to provide comprehensive dental care for the elderly under Medicare Part B, (H.R. 1015) and mandate dental services under Medicaid for children of low income families, (H.R. 4962).

This recognition of a federal role does not, however, include the provision of dental services in those areas where dental care is available from the private sector. Nor does it extend to the support of those federal health care delivery programs whose effectiveness can no longer be demonstrated. It is for this reason that the Association must express a strong objection to the projected size, cost and current program philosophy of the National Health Service Corps.

Recent statements by HEW officials indicate that the field strength of the Corps in 1990 will exceed 9,000 personnel. When this figure is applied to the Department's current cost estimate of $110,000 to establish and maintain a medical or dental Corps practice for the first year, the budget of the NHSC within 10 years will approach $1 billion. We do not believe that Congress or the American public is prepared to undertake such a costly venture.

The Association is also concerned that the Department has unilaterally changed the thrust of the Corps to such a degree that it bears little resemblance to the intent of the original law. We are particularly disturbed over the apparent shift in emphasis away from the solo practice delivery model to the promotion of a permanent federal presence in the form of fixed-site clinics. Department officials now indicate that a majority (80%) of future Corps dental placements will be in "integrated delivery systems", i.e. Community Health Centers and other fixed-sites. In addition to penalizing those underserved communities which do not have these health centers, this approach virtually precludes the evolution of Corps sites into self-sustaining private practices.

The validity of the private practice model for dentistry is clearly demonstrated by the experiences in Washington and other states included within HEW Region 10. Of the eight National Health Service Corps dental sites that have been established since 1972 in private practice settings, seven have converted to successful independent practices, and the eighth Corps site is expected to follow this pattern. Despite this impressive record, Region 10 is under the same pressure as all other HEW Regional Offices to give priority in dental Corps assignments to fixed-site centers.

Another negative aspect of the current operation of the National Health Service Corps can be seen in the low percentage of dental placements in underserved areas which are designated as having the greatest need (priority 01 and 02). The Association understands that almost 50 percent of all Corps dental assignments have to date been in areas with an 03 and 04 identification, the lowest quartile. This results in part from the emphasis on fixed-site placements and in the latitude allowed for site selection by NHSC personnel. It is also a reflection of the failure of Corps officials to work cooperatively with, and take into account the efforts of, local public and private groups in programs to improve access to care. By placing dentists in areas of marginal need, the Corps has placed itself in direct and unwarranted competition with private practitioners. These situations could be avoided if the local dental societies are given a more meaningful role in the designation of underserved areas and the possible placement of Corps personnel in these areas. At a minimum, there must be a greater opportunity for the local society to comment on proposed Corps assignments to their communities, and if appropriate and feasible, to offer less costly and more lasting alternatives to the NHSC. The Association strongly urges the adoption of amendments which allow a period of not less than 90 days for health professional societies to submit their comments during the designation and assignment process.

In summary, the ADA believes that the National Health Service Corps was enacted as an interim measure; one that would serve as a catalyst for the development of private practices. Unfortunately this concept has largely been abandoned as the Department has moved to create what appears to be a permanent federal health care delivery system.

Senate bill S.2144 proposes to shift the focus of service programs from the federal to the state level. This approach, at least in concept, deserves consideration. Present federal policy in the health care sector is toward local responsibility through a network of health systems agencies established under Public Law 93-641 and continued under P.L. 96-79. The basic assumption behind this thrust is that local planning organizations are in better positions than federal agencies at either a regional or national level to understand differing needs and patterns of care of local populations. A logical extension of this assumption is that state health departments are in a better position than the Department of Health and Human Services to evaluate need for publicly subsidized health professionals.

A second consideration for the establishment of state-operated service programs (in lieu of the NHSC) involves allocation of intra-state resources. Under the current program, professionals are assigned to shortage areas without regard to place of training. Since a majority of NHSC Scholarship recipients are graduates of northern schools while a majority of shortage areas are located in the south, this means that most

Corps professionals are trained in one state for four or more years and subsequently assigned to NHSC sites in another state. Where professional schools are subsidized in part by state revenues, this has the effect of unfairly reallocating resources from one state to another and acts as a disincentive to states to support training programs. In a program operated by the states, each state government could determine need for publicly subsidized professionals and could then invest in training and placement accordingly. This would have the further advantage that professionals drawn from and trained in a given state may be more likely to remain there and to effect long-range solutions to health manpower shortages.

A third advantage to a state-operated program involves licensing of professionals serving under public auspices. A continuing problem encountered with the National Health Service Corps has been the assignment of Corps professionals to sites in states in which they do not hold an appropriate license to practice. This occurs when professionals are matched to sites in states other than those in which they have previously trained or practiced. Corps members are required to take the required licensure examination at the earliest possible time, but this is often a significant period of time after the placement and in cases in which the professional fails to pass the exam, allowance is made for retaking it at the next opportunity. The result of this situation is that in many cases NHSC professionals provide care for extended periods of time without holding the appropriate license. If individual states trained professionals for service in those same states, it would be possible to provide for licensure arrangements based upon knowledge of the professional's educational background and to otherwise ensure that publicly supported professionals meet the requirements for practice in each individual state. This would both facilitate relationships with private professionals and inspire confidence among potential patients regarding the competence of the public service professionals.

There are two major deficiencies in this program as proposed in S.2144. The process of shortage area designation would remain, for reasons unspecified, a federal function. If the scholarship program is to be largely a state responsibility, then it should follow that the designation process, which ultimately determines the need for graduates with service commitments, should be a state function. There is a striking absence of information, in S.2144, regarding the placement process and operational requirements of the program. Given the wide range of problems encountered in the current federal program, it seems necessary to us that detailed legislative guidance be provided for any new initiative in this area. It is our experience that reliance on regulatory interpretation should be minimal for direct service programs.

The Association has developed a detailed set of recommendations on the existing NHSC program. We believe these suggested revisions (which are appended to this statement) can serve as the basis for statutory improvements to the current law and, where appropriate, as the framework for alternative approaches such as proposed in S.2144.

This concludes the Association's statement.

Enclosure #2

STATEMENT OF
THE AMERICAN DENTAL ASSOCIATION
ON
THE NATIONAL HEALTH SERVICE CORPS
(Summary of Recommendations)

I. The NHSC Scholarship Program:

- The number of scholarship recipients must be linked to a careful evaluation of the need for NHSC dentists in legitimate shortage areas which cannot be served by existing private resources;
- The selection process must be linked to the nature of the shortage areas. Participants should be those most likely to remain in shortage areas rather than those with greatest financial need. Priority for granting of scholarships should be second year students.

II. The Health Manpower Shortage Area (HMSA) Designation Process:

- Require that all requestors of designations consult both the appropriate HSA and local professional society and include their comments when submitting the request;
- Information requested from the professional society or any other relevant organization, should allow for a reasonable comment period - i.e. not less than 90 days;
- The criteria for designation of HMSAs must be improved to insure consistency in identification of shortage areas and to assure that all relevant factors are considered in evaluating designation requests.

III. The NHSC Placement Process:

- Require applicants for personnel to contact the appropriate professional society before submitting an application to request assistance in dealing with the shortage through use of existing private resources. Require the professional society's response to be included in the application;
- When requesting information from a professional society or other relevant organization, the Corps should allow a reasonable period in which to comment - i.e. not less than 90 days from date of receipt;
- Prohibit placements which would preempt any efforts initiated by private resources to deal with the shortage;

- Where NHSC dentists are placed to deal with special population groups designated as having shortages, require that such personnel may serve only members of that population group.
- Require that placement priorities for dental personnel be based only on degree of shortage groupings and that special efforts be undertaken to achieve placements in areas in which no dentists at all currently practice;
- Dental placements should not be linked to the existence of integrated sites funded under section 330 - the arguments for tying medical placements to integrated sites are not valid for dentistry;
- In areas where it can be demonstrated that private dental practice is an economically feasible way to reach the population at risk, require that Corps dental placements be on the private practice model;
- Require that the local professional society be involved in the process of recruiting a Corps dentist to serve in an approved placement site;
- Require that all Corps dentists obtain a license to practice in the state in which placed at the earliest available opportunity.

Detailed Recommendations

I. NHSC Scholarship Program:

Officals of the NHSC program have indicated that, as of December 31, 1979, a total of 770 dental students have been awarded service scholarships. Several hundred more scholarships are expected to be allocated for dentistry over the next five years. To date, however, only 860 dental manpower shortage areas have been designated as eligible for the placement of one or more Corps dentist. There appears to be little coordination between the number of scholarships granted and projected for dentistry, and the actual need for Corps members to serve in shortage areas. It is also important to recognize that the number of Corps dentists required is a function not of the number of shortage areas but rather of the existence of a viable sponsor and a site in which those dentists can effectively serve.

Past experience suggests that the scope of the Corps dental program has not been determined by a careful analysis of the number of dentists who can be viably placed but by the number of scholarship students completing training. In the opinion of the ADA, this has resulted in a situation in which considerable pressure is exerted on the NHSC regional offices to identify sites for scholarship dentists, whether or not viable sites actually exist. Because the integrity of the site is crucial to a successful placement, some Corps dentists are thus placed in areas of marginal need. (Nearly half of all dental placements are in 03/04 priority areas.) It would also appear that some areas have been designated as dentally underserved simply because those areas have a fixed-site health center which could support Corps placements.

It is clearly not possible to forecast exactly the number of placements in viable sites which will exist several years in the future. It should be possible, however, based on the Corps' experience with several hundred dental placements, to make reasonably accurate projections of the number of scholarship graduates which it can effectively utilize. Establishing the number of scholarships to be granted on projected placement opportunities would help to ease the pressure for designation of marginal shortage areas and would allow the Corps to concentrate its efforts on meeting the needs of the most serious shortage areas.

The National Health Service Corps was designed as a temporary mechanism to help meet the health care needs of underserved populations, many of which are rural and/or face special ethnic, racial, and language barriers to access to existing resources. Clearly, it is important that Corps personnel be carefully selected for characteristics which would enable them to address the special needs of the populations they will serve. Such matching would result not only in more effective services during the placement period but also in a greater probability for retention in the shortage area once the service commitment has been completed.

In selecting scholarship recipients, the program does appropriately give consideration to personal background and work experience in shortage areas as well as to career goals. However, priority is given to entering freshmen. Unfortunately, freshmen, with little direct experience with the dental care system, may have career goals which will change with exposure to intensive clinical education. It is certainly desirable to make contact with potential scholars at the earliest feasible date. It is also important, however, not to lock students into a service commitment before they have begun to develop an understanding of what that commitment entails.

It would be advisable therefore, to focus on the sophomore year as the preferred point for granting scholarships. The freshmen year could then be utilized as a period of intensive recruitment and education so that those seeking scholarships in the sophomore year would be equipped with a better understanding of what that commitment means for them upon graduation. This should result in fewer obligated graduates who find that service in the Corps is unsuitable to their personal or professional goals.

An additional problem in the selection of scholarship recipients is the issue of need for financial support. In some cases, those students who are most likely to serve effectively in shortage areas may indeed be those who also have the greatest financial need. However, there also appears to be a correlation between need for support and tuition costs of individual dental schools which is unrelated to the characteristics of students. It is very important, therefore, that NHSC scholarships not become a subsidy to those dental schools whose tuitions are highest. Not only is financial need an unreliable indicator of appropriateness for service in shortage areas, it is also a selection criteria which could have the undesirable effect of pushing low-income students into practices in underserved areas while more affluent students are able to pursue their respective careers unencumbered by shortage area service. There must be sufficient alternative sources of financial support to allow low-income students reasonable choices in selecting career orientations. Financial need should be deemphasized as a selection criteria for NHSC scholarships and should, in any case, be determined independently of differing dental school tuitions.

II. The Health Manpower Shortage Area (HMSA) Designation Process:

The point at which shortage areas are actually designated is perhaps the single most crucial point in the entire National Health Service Corps program. Corps personnel may only serve in areas which have been designated as Health Manpower Shortage Areas for the appropriate type of care (e.g.: medical, dental, etc.). It is thus of vital importance that areas designated as shortage areas be those which unquestionably do not have adequate resources to serve their populations. The two components of the health care system which are most likely to have the knowledge to assure that designations are appropriate are the Health Systems Agency and the local dental society or other relevant professional group.

Health Systems Agencies are invested with the responsibility for allocating scarce resources and for assuring that the health care system within each health service area provides accessible high quality care in the most cost-effective manner possible. As such, the HSA should have a comprehensive view of the needs of its health service area. The local dental society on the other hand, has the most complete view of the situation in terms of providing high quality dental care to the population. It has the best possible understanding of the local dental manpower situation and of the utilization of those resources. The American Dental Association has encouraged its constituent (state) societies to identify true dental shortage areas within each state and to match such areas with those identified under the National Health Service Corps Program. It is absolutely essential, therefore, that both the HSA and dental society perspectives be fully represented in the designation process.

Existing regulations specify that the HSA must be consulted by the Shortage Area Designation Staff before a final decision is made on a designation. The regulations do not require that the local dental society be involved at any point in the designation process.

Any applicant seeking designation of a dental shortage area should be required to consult both the appropriate Health Systems Agency and the appropriate local dental society prior to submission of a designation request. The applicant should be required to include in its designation request, documentation of that prior consultation as well as of the HSAs' and the dental societies' positions on the appropriateness of the request. Failure to do so should constitute grounds for denial of the designation request.

In order to ensure that the input of the HSA and the dental society is based on a comprehensive investigation of the proposed designation, each of those organizations should be allowed a reasonable period in which to evaluate the designation request - i.e., not less than 90 days from date of receipt. The Association respectfully recommends the adoption of appropriate statutory amendments to effect these changes.

The task of identifying areas with shortages of health manpower is a complex one. No two communities or population groups are exactly the same, no do they have identical health care needs. Therefore, it may not be possible to develop criteria for identifying shortages which are completely objective and quantifiable. The existing criteria for designation of dental shortage areas attempt to be objective in ways which often produce limiting and inaccurate results while providing too little objective guidance in certain other areas. The result has been considerable confusion and inconsistency in interpretation of the criteria and in the characteristics of the dental shortage areas which have actually been designated.

The American Dental Association's Bureau of Economic and Behavioral Research has prepared a detailed analysis of the criteria for designation of dental shortage areas, under contract to the Department of Health, Education and Welfare ("Assessing Supply of Dental and Auxiliary Personnel and Requirements for Dental Health Personnel by Specialty and Geographic Location,"). This analysis, which is included as an appendix to this statement offers a critique of specific aspects of the criteria and suggestions for improvements.

III. The Placement of National Health Service Corps Personnel:

Current regulations specify that the NHSC must solicit the comments of Health Systems Agencies and local professional societies on applications for placement of Corps personnel. The present comment period allowed these organizations is 30 days. As in the case of applications for designation of shortage areas, this regulated involvement of HSAs and professional societies is too little and too late.

Just as it is crucial that the appropriate HSA and local dental society be involved throughout the process of identification of shortage areas, so too, it is vital that they be involved in all efforts to alleviate shortages. The placement of NHSC dentists is only one of many potential strategies for meeting the needs of dental shortage areas. Among other alternatives are the redistribution of existing private dentists and the recruitment of new private dentists. (The ADA is sponsor of the National Health Professions Placement Network, which is designed to help meet just such needs.) Early involvement of both the HSA and the dental society can assure that the needs of shortage areas are met in the most cost-effective manner possible. It can also help to prevent costly duplication of resources. Clearly, it would be counterproductive to place an NHSC dentist in an area in which a private dentist is planning to open a new practice, yet such situations have occurred due to insufficient communications and cooperation. This results in substitution of a NHSC dentist for a private dentist with no increase in supply of services and in higher costs.

Any applicant seeking placement of NHSC dental personnel should be required to consult both the appropriate Health Systems Agency and the local dental society prior to submission of a placement request. The applicant should be required to include in its placement application documentation of that consultation as well as of the HSAs' and the dental societies' positions on the appropriateness of the proposed placement. Failure to do so should constitute grounds for denial of the application.

In order to ensure that the input of the HSA and the dental society is based on comprehensive investigation of the proposed placement, the current law must be amended to allow each of those organizations a reasonable period in which to evaluate the application - i.e., not less than 90 days from date of receipt.

The regulations now require that the Corps also solicit the comments of the State Health Planning and Development Agency on any placement request. Complimentary to requesting comment from the SHPDA, the state dental society's comments should also be solicited. This would assure comprehensive input from planning agencies and the dental profession at both state and local levels. In addition the Corps would be well advised to solicit the input of the Dental Director in each state's Department of Health.

The need to avoid duplication of private resources by NHSC personnel is of utmost importance. Therefore, the National Service Corps should be precluded from placing Corps dentists in areas which would preempt or compete with any reasonable efforts which have been initiated to deal with shortage situations through the use of private resources. Dentists who enter a shortage area to establish a private practice or to work in a private facility are far more likely to remain in the area than are dentists placed by the NHSC. Such private dentists are a preferred alternative for relieving shortages wherever possible.

A similar problem of potential duplication of resources exists where NHSC dentists are placed to serve special population groups. Under the regulations for designation, it is possible to designate shortage populations as well as geographic shortage areas. Such populations are often located in geographic areas which have adequate numbers of dentists to meet the needs of the majority of their populations. The special populations, however, have inadequate access to services because of socio-cultural factors such as language barriers. (The difficulties of accurately identifying socio-cultural access barriers were discussed earlier). Where this type of shortage population does clearly exist, care must be taken to ensure that any federal resources intended to alleviate the shortage are in fact utilized only by the shortage population.

It is inappropriate for National Health Service Corps dentists who are placed to serve a special population to be utilized by members of other groups who have access to private resources. Such a situation can result in unfair competition through providing care at lower than market-prices and thus would force private dentists to leave the area. This would have the unacceptable effect of actually worsening the area's manpower situation at the same time that the target population receives less than the maximum benefit intended by the Corps dentist. It should, therefore, be clearly specified in law that any NHSC dentist who is placed to serve a shortage population may provide non-emergency services only to members of that population group.

Congress must also ensure that NHSC dentists are placed in those shortage areas which have the greatest need. The existing criteria for HMSA designation provides for a system of grouping areas by degree of shortage, with the "01" classification representing the most critical shortage and "04" the least. In practice, however, the Department has assigned an unacceptably high percentage of Corps dentists to those areas designated as having a lower (03 and 04) priority. This results in part from the latitude allowed for site selection by NHSC dentists and, in particular, from the Corps' shift in emphasis to "integrated" delivery systems or fixed-site health centers as the preferred delivery mode. The Department has recently indicated that a majority (80%) of future Corps dental placements will be in Community Health Centers and other fixed-sites. Whatever advantages may be perceived to exist by adopting this approach, it is mitigated by the fact that, for dentistry, most of these sites are in the 03/04 priority areas. This policy has, in addition, the immediate effect of penalizing those rural and urban communities which do not have fixed-site health centers. Of most importance is the fact that the placement of Corps dentists in these semi-permanent facilities virtually precludes the conversion of this form of NHSC delivery mechanism to a private practice; an objective which was a central feature of the original NHSC legislation.

It is important to recognize that the solo practice model is the dominant characteristic of the dental care delivery system. Because of the profession's emphasis on primary care (almost 90 percent of dentists are general practitioners) referral relationships and other linkages which are necessary for medicine are less critical to dentistry. The validity of the dental private practice model as a long-term solution to access problems is demonstrated by the experience of the National Health Service Corps in HEW Region X (Alaska, Idaho, Oregon and Washington). Of eight private practice model NHSC sites established in Region X since 1972, seven have converted to successful private practices and the eighth is expected to follow this pattern. Based on this experience and on the nature of dental practice, the National Health Service Corps should be required to utilize the private practice model for dental placements in all shortage areas in which it can be demonstrated that private dental practice is an economically feasible way to reach the population at risk.

National Health Service Corps dentists must also be effectively integrated into their professional communities and thus encouraged to remain upon completion of the placement.

One way in which the professional relationships of Corps providers could be improved would be through greater involvement of local private dentists in the recruitment process. This would permit experienced dentists to bring their technical knowledge and understanding to bear in the selection process. It would also ensure that local providers were familiar with and confident of the new dentist at the outset of the placement, facilitating integration into the community as a whole. The NHSC should therefore be directed wherever possible to involve representatives of the local professional community in the recruitment process.

A more specific problem involves licensure. Each state has its own licensure requirements and it is essential that Corps dentists be licensed in the state of placement if they are to be respected and supported by their colleagues. In a number of cases, newly graduated dentists have been placed by the Corps and have then been unable or unwilling to obtain their licenses. The timing of graduation, placement schedules, and licensure exams may be such that dentists in some cases must be placed prior to taking the licensure exam. However, the Corps must do everything possible to minimize such situations, and it must not abide with dentists who are unable or unwilling to obtain their licenses. A serious question must be raised about the quality of care provided by a dentist who cannot or will not obtain a license. All National Health Service Corps dentists must be required to obtain a license to practice in the state in which placed at the earliest possible opportunity. No dentist should be placed who cannot be reasonably expected to do so and all efforts should be made to see that licensure precedes final placement wherever possible. Failure to obtain a license should be grounds for removal from placement.

Mr. **Waxman**. Thank you very much for your testimony.

The Federal Government has provided significant assistance to schools of the health professions over the past decade but this assistance has always been tied to a response to some national problem. In 1971, in particular, the schools were required to increase their enrollments. More recently, in 1976, the legislation spoke, perhaps inadequately, to concerns about primary care. Dr. Richmond has suggested that primary care, geographic distribution, and disadvantaged students are all-important national problems.

I would like to know from each of you how your proposals would respond to each of these problems. Dr. Stemmler.

Dr. **Stemmler**. Let us talk about the role of the school as an instrument of innovation and change. It seems to me, it is hard to talk specifically about the programs that get mounted and directed, using the word we have heard here earlier, in "targeted" ways.

The schools probably are the most resourceful apparatus available to the Federal Government to promote change in the health scene. It seems to me that they have served that role very effectively.

The primary care movement, as we call it, evolved, in part, through actions taken by the schools and, in part, through actions taken by professional associations. Those actions were then implemented cooperatively with schools. I am referring to, for example, the family practice movement, the trend in the establishment of general medicine as an area of concern, the promotion and development of residency programs in the community institutions, and the support of those institutions with educational programs so that they attracted American graduates.

It is in all of those ways that the schools have played a major role and because of that we are now seeing trends in a very positive direction. I would have to emphasize that we are in a dynamic and positive situation at the present time.

In the area of minority recruitment——

Mr. **Waxman**. Before we leave that area, it seems that the schools have played a role in the trend in the other direction, the specialization and concentration on subspecialization by so many of the students, which has led to a surplus in some of the specialties while at the same time we have an insufficient number of general practitioners. Do you agree?

Dr. **Stemmler**. I don't think the schools can step aside from being called to account. I am referring now to the period in the early fifties and sixties, where there was a great emphasis on the development of specialties, the definition of new specialties, and the interest of students in pursuing careers there.

You recognize, of course, Mr. Chairman, that the schools address 4 years of education and then the students graduate and enter the graduate years in which they elect to do things that are no longer directly under the control of the schools. Society has encouraged them also to broaden their education and to go into greater depth.

But it seems to me that if we define that as an adverse trend—and I am not sure we should—I think we saw something grow that had to grow to provide high-quality services and now we are in a period where all of us agree that it has to be adjusted for a more favorable distribution toward individuals who provide primary health services but without trying to compromise the strength of that specialty system which is in place and which serves us so well.

Mr. **Waxman**. Do you want to comment on the other?

Dr. **Stemmler**. I wanted to comment on minority recruitment and retention because I must say that those of us in medical education are very much discouraged about the scene as we see it. The Association of American Medical Colleges had really declared, as one of its missions, to try to promote the entry of individuals who are both underprivileged and representatives of groups that are not well represented in medicine, and many serious attempts through a variety of programs have been made.

I can speak to our own experience at the University of Pennsylvania, where the tactic that we took was to try to generate a pool of applicants through a program that goes and visits undergraduate colleges. We try to promote or to encourage students to apply and, from that pool, to accept a group that will come and join our class.

Within the last 5 or 6 years the pool of applicants has probably quadrupled but the number of students who choose to enroll in our school, despite the large number of acceptances, has declined.

There are a variety of factors and we try to look at why students turn away from us. One of the factors is financial. Others relate to opportunities that students perceive are available in other careers where there is a more immediate reward than pursuing training in medicine.

So, I am really very much dissatisfied, as are my colleagues, in that the national applicant pool has remained relatively constant over the last 4 or 5 years and that, despite programs such as those that Dr. Richmond addressed, we have not really increased the number who appear to be applying.

I saw a study of college freshmen recently from the American Council on Education where students expressed their interest in future careers. In the group of freshmen, generally there was a decline in the number interested in medicine, but in the minority group particularly there was even a further decline.

Mr. **Waxman**. Dr. Roeck.

Dr. **Roeck**. I welcome the opportunity to speak on the issue of the primary care, as you mentioned, Mr. Chairman, because that is one of the areas where dentistry is quite different from medicine. Practitioners in dentistry are in primary-care areas in an overwhelming majority. The number of specialists in the practice of dentistry is somewhere in the neighborhood of 10 or 12 percent. I could get the accurate figures for you if you would like. But our situation is almost an upside-down situation compared to what has been true in the medical profession.

We support the continuation of support for the general practice residency program so that we will not get into an area where most of the graduates are attempting to go into specialty programs. We support the program that is currently in effect under the present law encouraging the establishment of general practice residency programs, also programs in pedadontics, children's dentistry.

On the subject of minority——

Mr. Waxman. You don't object to the provisions that we have in our bill?

Dr. Roeck. No, sir.

Mr. Waxman. Dr. Pumerantz.

Dr. Pumerantz. Mr. Chairman, this is probably the happiest question for the osteopathic profession to answer because indeed all of osteopathic medicine has been the preparation of primary-care physicians. And, as I indicated in my remarks, this profession from its very beginning has devoted itself to the whole question of training primary-care physicians.

I think our track record is very effective in this regard. We are very happy to find that 80 percent of our graduates indeed go into primary care and the other 20 percent go into osteopathic specialties, which is just the reverse of our allopathic brethren.

I think the whole question of devoting our attentions as a profession to primary care has always been a happy occasion for us. We are delighted to always present that. So we support the provisions in your bill on that.

On the question of the minorities, we, too, share the same problems of recruiting minorities, although our association of colleges has developed a program on health careers, an opportunity program that attempts to recruit and to channel minority students into our colleges.

Mr. Waxman. HEW reports show that the percentage of primary care residents and trainees in each of the past 3 years has been 52 percent. So no change has been shown. How would you explain that, Dr. Stemmler?

Dr. Stemmler. This is the number that is determined by the number of first year entry positions minus those who move out of those positions, I assume.

Mr. Waxman. Yes.

Dr. Stemmler. I guess the best way to respond to that is not to challenge a number but to talk about what we would hope would be a trend, also to look at another facet of it, and that is: How we define the primary-care physician.

The issue really is not necessarily the deduction at the first year but what happens as the resident in medicine, continues his or her education and then at the third year of training elects to enter a specialty training. Of course, that is the area to which your bill is addressing itself as an additional deduction.

Now, the question—and it is really the basis on which the philosophy of the bill is constructed—is whether there is such a thing as a primary-care physician who is purely and simply primary care? You would, on that assumption, reject the notion that the specialty physician provides, in a percentage of his time, significant primary health care services, services which have been shown to be provided by recent information, an assertion which had been argued by the internists all along.

The concern we have is on that difference in perception. We do not believe that we can quantify now, based upon a numerical deduction, whether we are producing an adequate number of physicians who are providing services that would be defined as primary health care services for the population.

We believe that the information available shows that the trend is improving—that is, that there are more services provided through a diversified apparatus, not a pure apparatus of only people called primary-care physicians. We therefore advise that we not disturb or make Federal intrusions into that trend until we can watch it along and see that it continues to go in the correct direction.

Mr. **Waxman**. I assume that what you are saying is that the direction in which it is going is the correct direction.

Dr. **Stemmler**. Our belief is that, at least as far as the evidence available to us can show, it is going in the correct direction. I am referring now to information that comes from the Mendenhall study and the Linda Aiken study, also information that is in the Rand report. These reports show some evidence that there is a migration of physicians and that there is a significant fraction of time provided by specialists in the delivery of primary health services.

Mr. **Waxman**. Do you think it is a mistake to think that we ought to have primary-care physicians to take care of a comprehensive and preventive approach for the family as opposed to just expecting that specialists also will deliver some amount of primary care and it will all take care of itself?

Dr. **Stemmler**. I believe that every American ought to have a physician available to that citizen for what we call the delivery of primary services, somebody who is personally related and who knows the nature of the care needed by that person. But my belief is that that person does not necessarily have to be called a primary-care physician. It ought to be a physician who provides that service and, for people who have chronic illness, it may very well be their cardiologist, their diabetologist or their rheumatologist who establishes that long, close, personal relationship and knows the nature of the care that should be provided.

Mr. **Waxman**. In recent years the amount of capitation actually provided to schools has decreased. I would like to know from each of you: What are the current costs of education per student in each of your schools, what percentage of that amount does capitation represent and what about tuition levels, what share of costs are met from tuition?

Dr. **Stemmler**. I will respond first, if that is all right, and that is to say that the relationship between the capitation and the tuition level is clearly not a one-to-one relationship. We view the capitation or institutional support as support that provides unrestricted dollars for the variety of programs that schools deliver on behalf of national policy. And the evidence for that use is in a report by the General Accounting Office.

The funding of a school comes from a variety of sources. What has changed over these years with the reduction of capitation has been changes that have been driven by the need to maintain the array of programs expected by modern medical schools. For example, medical faculties now organize themselves to practice medicine and contribute part of what they earn in their practice toward the support of the school. That is, in part, a contribution made in a special way to the educational institutions. Many States have increased the level of funding to the schools because there has been a decline in the Federal dollars.

So, to answer quantitatively, I would have to say that I guess the capitation has dropped something like $1,300 since about 1974 and tuitions in the private schools have risen by about $2,500 and in the public schools by maybe $1,000. But again I wouldn't want to tie those numbers directly to a one-to-one relationship with capitation.

Dr. **Roeck**. At my own school, Mr. Chairman, the cost per student is somewhat lower than it is on average throughout the country. Our cost per student runs roughly $15,000 per student per year. Our capitation grants at the present time represent roughly 6 percent of our total operating budget.

The tuition has increased regularly and, as was just stated, not in direct proportion to the capitation; there are many other factors that enter into that. But our tuition has increased over the past 2 years on a regular basis and increases each year to the point where we are now charging residents of Pennsylvania $4,500 a year and nonresidents are paying $7,650 per year.

One thing that I would like to mention in relation to dental education is that our students have sizable costs related to instruments and supplies that they must buy. Our freshman and our sophomore student instrument kits this year total $5,400 in addition to their tuition requirements.

Dr. **Pumerantz**. Mr. Chairman, our picture is essentially the same. I am not sure we can tie our tuition increases directly to the decline in capitation. I don't have all of the figures, which we will get for you, but I do know that among our colleges the tuition ranges all of the way from $600 in one of our State schools to $10,000 in a couple of our private schools, which is very high.

Clearly the need to raise tuition has been affected by the decline in capitation. The cost per student per year generally—I don't have the figures but our staff can get them for you—generally in osteopathic colleges they are, I think, lower than at some of the other medical schools.

Mr. **Waxman**. I am interested in knowing how your schools use the capitation funds.

Dr. **Stemmler**. In the operation of a medical school the bulk of the funds come in what we call restricted categories. Endowment income, Federal research grants, special project grants are all targeted for specific purposes and can't be used in a general way.

I represent a private school. The value of the institutional support provided to our schools is that it provides a source of unrestricted funds that enable us to initiate, innovate, to sort of glue together the areas in which there are lapses of funding on the one hand and something we have to do on the other.

That is the value. They are really funds of a special nature. As you point out, it is not a very high percentage of our total budget, but it is the kind of fund that makes a school run.

Dr. **Roeck**. The capitation funds that we get at the Temple University Dental School are used almost entirely for salaries for faculty and staff.

Dr. **Pumerantz**. I think that, by and large, these are unrestricted funds that are used in operations, usually in operational budgets.

Mr. **Waxman**. I think next week we will hear about student assistance from the students' associations. But I am interested in your views on this situation. Do you know what the median-family income of your students is? What about the mix of financing they obtain? Do most of the students get some money from families, summer jobs, or do they borrow the funds? What about the students from the lower-income families? Are current Federal efforts targeted specifically to these students?

Dr. **Stemmler**. Without trying to answer in specific numbers, which we can provide, the financial aid area is clearly an area of vital need in medical education today. We are in a terrible plight whether or not there is institutional support provided independently of this question.

The issues really tie to points that Dr. Carter made previously in his questioning of the administration. The basic costs—that is, the high cost of tuition and the living expenses—and the fact that medical students typically can't engage in work-study kinds of projects; they are fully committed in their educational programs, so they don't have the availability to engage in outside positions that help to fund themselves. We are trying to provide access to medical education for students from a broad distribution of family income.

Most of our students now, by the nature of the cost of education, are needy students, and the great need is in the availability of financial aid. We agree that students ought to defray the cost of their education to a reasonable extent. The money ought to be available and it ought to be available at a reasonable interest cost. Students ought to be able to manage their debt in such a way that it doesn't disrupt their career development.

We are talking about students who, by their nature and their ideals, are to be expected to operate at the very highest of motives. The financing should not be couched in a way that distorts those motives. At the present time the nature of the environment does distort higher motives.

So, speaking very generally—and we would be glad to provide the specific information—I would say that, of all of the issues we have discussed, financial aid is the area of greatest need.

Mr. **Waxman**. We would like to have more specific information for the record.

[The following letter was received for the record:]

Chicago College
of Osteopathic Medicine
5200 Ellis Avenue
Chicago, Illinois 60615

College of Osteopathic Medicine
and Surgery
3200 Grand Avenue
Des Moines, Iowa 50312

College of Osteopathic Medicine
of the Pacific
309 Pomona Mall East
Pomona, California 91766

Kansas City College
of Osteopathic Medicine
2105 Independence Avenue
Kansas City, Missouri 64124

Kirksville College
of Osteopathic Medicine
Kirksville, Missouri 63501

Michigan State University
College of Osteopathic Medicine
East Fee Hall
East Lansing, Michigan 48824

College of Medicine
and Dentistry of New Jersey
New Jersey School
of Osteopathic Medicine
300 Broadway
Camden, New Jersey 08103

New York College
of Osteopathic Medicine
New York Institute of Technology
Wheatley Road, P.O. Box 170
Old Westbury, L.I., New York 11568

Ohio University
College of Osteopathic Medicine
Athens, Ohio 45701

Oklahoma College
of Osteopathic Medicine
and Surgery
1111 West 17th Street
Tulsa, Oklahoma 74101

Philadelphia College
of Osteopathic Medicine
4150 City Avenue
Philadelphia, Pennsylvania 19131

North Texas State University
Texas College
of Osteopathic Medicine
3516 Camp Bowie Boulevard
Fort Worth, Texas 76107

West Virginia School
of Osteopathic Medicine
400 North Lee Street
Lewisburg, West Virginia 24901

AACOM
American Association of Colleges of Osteopathic Medicine
4720 Montgomery Lane, Suite 608, Washington, D.C. 20014. (301) 654-5800

March 31, 1980

The Honorable Henry A. Waxman
Chairman
Subcommittee on Health and
the Environment
House Interstate and Foreign
Commerce Committee
2415 Rayburn House Office Building
Washington, DC 20515

Dear Congressman Waxman:

Testifying on March 20 before your subcommittee on H.R. 6802 and related health manpower proposals, this organization was requested to provide additional data concerning institutional and student educational costs. The following are our responses; should you require further clarification, we will be happy to provide it insofar as possible.

I. Institutional Costs

Educational costs to the institution, calculated on a per pupil/per year basis, average $17,000, in contrast to an average cost to students of approximately $13,000 per year. Tuition in colleges of osteopathic medicine ranges from $300 to $9,000 for instate students, and from $900 to $9,000 for out-of-state students, the wide variation reflecting the differential between public and private institutions. The mean and medran tuitions for all 13 schools are $4,851 and $5,175 for instate students, and $5,785 and $6,000 for out-of-state students respectively. Capitation represents between 2 percent and 7 percent of the total institutional budget for most schools, and most utilize such funds primarily for general operating expenses, although in at least one case capitation support is applied to various primary care programmatic activities exclusively.

II. Student Assistance

Students at the colleges of osteopathic medicine derive their income from the following sources, in the indicated average amounts; no

II. Student Assistance (continued)

information is available regarding median family income or parental contribution as a percentage of total student support, although we are hopeful that we will be able to make this information available in the future.

Source	Amount	% Total
Earnings	$2,601	20
Loans	6,275	48
Scholarships	4,121	32
TOTAL	$12,997	100%

Sincerely,

Laura E. Levine, Director
Office of Governmental Affairs

LEL/wb

cc: Anthony J. McNevin
Executive Director

Dr. **Roeck**. We have a very serious concern in the dental schools about pricing ourselves out of the market so that only students from upper level income families would be able to study dentistry. A report was just published by the American Association of Dental Schools which indicates that roughly 8 or 9 percent of the students in dental schools today come from families with incomes of less than $10,000. And, of course, the percentage of people in the population who have incomes of less than that is considerably higher.

Of all of the respondents to the questionnaire that was sent out by the American Association of Dental Schools, 77 percent of the students expected to have to apply for financial aid to cover some of their educational costs. The estimated debt at the end of their dental school careers came to $22,500. There are many students whom I know personally who are graduating with debts on their hands of $45,000 to $50,000 at the present time. In addition to that, the estimate on the cost of operating a dental office today is $42,000.

So all of these extreme costs that the students are facing in dental education undoubtedly are contributing to the reduction in the number of applicants to the dental schools.

Dr. **Pumerantz**. Mr. Chairman, our association is in the process of completing a survey and I will have that information for you in a week, but the whole question is really probably the most crucial and sensitive one that our colleges deal with. We are always concerned that we don't get students who are smart enough to choose rich parents. That is always our major concern.

Mr. **Waxman**. I understand exactly what you mean. We will look forward to hearing the result of your survey.

[The survey referred to was not available to the subcommittee at the time of printing.]

Mr. **Waxman**. Dr. Stemmler, do you feel that the curriculum of the American medical schools places enough emphasis on the effects on human health by environmental contaminants? If not, how do you suggest that we remedy the situation? Should we earmark funds especially for section 788(d)(8) project grant authority for startup assistance for environmental health education and preventive medicine?

Dr. **Stemmler**. Mr. Chairman, I would certainly support the idea that environment health education represents the kind of a special project that deserves investment by the Federal Government. There are many schools now attempting to draw into the schools of medicine programs that link to medical education the concerns about health and the environment, the toxicological, and epidemiological preventive aspects of health.

The individuals who are faculty-qualified to assume those roles in the schools of medicine are in short supply. We are probably going to have to raise a generation of faculty who fit closely within the structure of schools of medicine. And I would certainly encourage you to support a position on a special project that would include that in the legislation.

Mr. **Waxman**. I know that the AAMC has recently issued a report on graduate education. One of the points made there is that it is easier to finance specialty education programs than primary care programs. Have you or your people had a chance to review title V of our bill and do you think some changes in this area would be helpful?

Dr. **Stemmler**. Yes, we have had an opportunity, and we certainly agree and strongly support the notion that there is a need to remedy the problem of inadequate support for education in the primary care setting.

We are much much concerned about the specific proposal made in title V, which we fear may set up a differentiation in class of residents. We would like very much to work with you to try to restructure that proposal in ways that might be helpful to address a need on which we are very much in agreement with you.

Mr. **Waxman**. I will look forward to working with you on that. Thank you very much. Dr. Carter.

Mr. **Carter**. I notice that you stated that dental student expenses are about $12,000 for tuition and board for 1 year.

Dr. **Roeck**. I quoted figures from my own school.

Mr. **Carter**. Those are the figures at your own school?

Dr. **Roeck**. And it depends on whether we are talking about a resident student or a nonresident student. A nonresident student has fixed school expenses of roughly $12,000 a year without any of his personal living expenses.

Mr. **Carter**. $12,000 above his personal expenses?

Dr. **Roeck**. Yes.

Mr. **Carter**. What would you estimate to be the total cost per year?

Dr. **Roeck**. I guess it has to be in the neighborhood of $18,000 to $20,000.

Mr. **Carter**. $18,000 to $20,000. And while the former interest rate under HEAL was 12 percent, under the administration's proposal it would be 19 percent; is that correct? And under this it would be, I guess, 19 percent; is that correct?

Dr. **Roeck**. Pardon?

Mr. **Carter**. Under the administration's proposed legislation the interest rate would be about 19 percent. Do you have any estimate of what the total cost of a loan to finance dental education would be then?

Dr. **Roeck**. I don't have exact figures but you have to include in the figures the 8 years, the 4 years of predental education as well as the dental education, in the total cost.

Mr. **Carter**. Yes. What would you estimate as the cost per year at an ordinary medical school for tuition, living expenses and all?

Dr. **Stemmler**. Dr. Carter, you have to look at the difference between the private and the publicly supported schools. In the private school—and I will use my own as an example—our tuition next year will probably be $8,700, and we estimate that the living expenses in Philadelphia as a student would be about $6,000.

So, in round numbers, that the educational cost for a medical student in Philadelphia next year will be about $15,000.

Mr. **Carter**. That is total?

Dr. **Stemmler**. That is total.

Mr. **Carter**. And it would be no less than $60,000 for the 4 years if you ignore the inflation factor for the moment.

Dr. **Stemmler**. That is correct.

Mr. **Carter**. And what would the interest rate be now according to the proposed legislation? Approximately 19 percent?

Dr. **Stemmler**. The administration says to go out on the open market, a suggestion which is just absolutely unrealistic. It is unrealistic on two sides. One, because the interest rates are extraordinarily high, but on the second side there is no assurance that the banks will lend the money to medical students even at market rates.

Mr. **Carter**. Yes. I notice that in the period 1973-74 to 1979-80 the tuition for dental schools went up 126 percent. Can you explain why you had the drop there of applications of 22 percent during that time?

Dr. **Roeck**. I think the increase in tuition is one of the factors affecting the decrease in the number of applicants. A study was done to try to determine all of the factors, and there were a number of things identified. One of the other major ones is that opportunities exist in some other scientific fields today that do not take as long to accomplish and are not as expensive as medicine and dentistry. It appears that many of the students who are interested in science areas are turning to some other fields besides medicine and dentistry.

Mr. **Carter**. Yes; I think that might well be the reason with the cost being what it is for not just the 4 years of medicine, internship and residency but also the 4 years previous to that if you count all of it in. That is a tremendous investment.

What would be the likely behavior of a young doctor beginning his practice if he had to repay such a large loan? What about his fees?

In fact, what would he have to do in order to pay back such a large debt for the cost of his medical education? What would he have to do?

Dr. **Stemmler**. I think we can speculate. Obviously it will influence a variety of areas, including the one that you are addressing, that is the billing of patients at some future time at an inflated rate above the rate now——

Mr. **Carter**. He would have to charge more, wouldn't he?

Dr. **Stemmler**. That is correct. The second undesirable effect is that he or she may choose a career preference on the basis of the economic factors. We don't know whether that shift toward high income specialties is operating as of yet but we will certainly be watching that very carefully. The third effect is that a student may not come into medicine.

Mr. **Carter**. I didn't understand that.

Dr. **Stemmler**. Students may not continue to apply in the same numbers. We are seeing a decline in applicants. We have had a 15-percent decline over the last few years.

Mr. **Carter**. I noticed that. At the present time we are supposed to have 444,000 M.D.'s in this country. There is a projection given by persons in authority that by 1990 there will be 574,000 physicians in this country. With conditions as they are, with tuition increasing, with capitation being removed and with living costs going up, do you think that we will reach that goal of 574,000 physicians by 1990?

Dr. **Stemmler**. I don't know whether we will, but, I think that there is every evidence at the moment that we will.

Mr. **Carter**. There is every evidence that we will reach that number?

Dr. **Stemmler**. There is evidence that we will reach that number if the enrollment in the medical schools holds constant.

Mr. **Carter**. Will it hold constant with increased tuition and increased indebtedness?

Dr. **Stemmler**. I don't know.

Mr. **Carter**. With the removal of capitation and the other things which we have done to encourage increased enrollment, what do you think, Dr. Sherman?

Dr. **Sherman**. Dr. Carter, I think it is a matter, as Dr. Stemmler said, of speculation, but there have been historical cycles in terms of the proportion of applicants to available places over a number of decades. One could speculate, I think, rather confidently that we probably could reach that figure——

Mr. **Carter**. If we continue with our present incentives. But if we take them away, I believe that figure will go down.

Dr. **Sherman**. Or we will fill those places with only qualified individuals from the most affluent families.

Mr. **Carter**. That is, the poor, and the disadvantaged, would not be given a chance.

Dr. **Sherman**. Yes.

Mr. **Carter**. I am interested in your reactions to the primary care requirement in our legislation. Specifically I would like to know whether you feel that this percentage requirement would be more viable if the following option were included: that in the event that the national primary care percentage goal is not met in the aggregate, each medical school could still receive institutional support if it could show that it had achieved a 5-percent growth in the number of its first-year primary care residency training positions over the previous year.

Schools that could meet the national goal would still be able to receive institutional support but, under this modification, the school would have two ways to qualify for funds. I believe that this approach would encourage medical schools to take an active interest in primary care, without imposing unreasonable goals. Would you comment?

Dr. **Stemmler.** Dr. Carter, I think that that suggestion is an improvement over the position taken in the original writing of the bill; but the medical schools have a fundamental concern, and that is that the number of resident physicians and their distribution are not under the control of the medical schools.

Mr. **Carter.** Absolutely. We know that.

Dr. **Stemmler.** Therefore we are being asked to accomplish a change that we are not in a position to control. And it is on those fundamental grounds that we express our concern.

Mr. **Carter.** I have a letter from Dean Clawsen, from the University of Kentucky to that effect right now. I believe, Dr. Keeney from the University of Louisville would also probably agree with you.

Gentlemen, it has been very nice to have had you here today, and I have enjoyed working with you over the years. Thank you.

Mr. **Waxman.** Thank you, Dr. Carter.

Gentlemen, thank you very much for your testimony. We look forward to working with you on this legislation and other problems as they come up. We appreciate your being here.

Let me announce that the subcommittee will continue its hearings on this legislation at 10 a.m. tomorrow morning in room 2322.

[Whereupon, at 4:50 p.m. the subcommittee adjourned, to reconvene at 10 a.m., Friday, March 21, 1980.]

HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE AND NURSE TRAINING ACT OF 1980

FRIDAY, MARCH 21, 1980

House of Representatives,
Subcommittee on Health and the Environment,
Committee on Interstate and Foreign Commerce,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2322, Rayburn House Office Building, Hon. Henry A. Waxman, chairman, presiding.

Mr. Waxman. The meeting will come to order. We are continuing our hearings on the health manpower bill. Before I call upon our first witnesses, I would like to call on our colleague, Congressman Lou Stokes, to make a presentation to us and introduce our first witness.

We are delighted to have you with us this morning.

STATEMENT OF HON. LOUIS STOKES, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. Stokes. Thank you very much, Mr. Chairman.

Mr. Chairman, and members of the subcommittee, I am delighted this morning to have the opportunity to introduce to your subcommittee, Dr. Ralph Hines, who is the provost and executive vice president of Meharry Medical College, in Nashville, Tenn., and Dr. Walter Bowie, dean of the School of Veterinary Medicine at Tuskegee Institute, in Tuskegee, Ala.

They are representing a consortium of seven minority health profession schools, which includes in addition to their schools, Charles R. Drew Postgraduate School of Medicine, in Los Angeles; the School of Medicine at Morehouse College, in Atlanta; the School of Pharmacy at Florida A. & M. University, in Tallahassee; School of Pharmacy, Texas Southern University in Houston; and College of Pharmacy, Xavier University Louisiana in New Orleans, La.

With the exception of Howard University, which has a special Federal relationship, the schools of the consortium are the principal training centers in medicine, dentistry, veterinary medicine, and pharmacy for black students in the country.

The Consortium of Minority Health Professions Schools has been formed because of the common goals, interests and needs of these institutions.

Their impact and contributions to the health care delivery system, especially in underserved communities, is significant. These schools have been called national priority institutions in that they are truly national resources and, as such, have a special relationship with the Federal Government.

I am pleased at this time to present these witnesses to you, Mr. Chairman.

Mr. WAXMAN. Thank you very much for taking the time to come before us, and to make that introduction and to express your interests, which I believe the members of this subcommittee also share, that we not abandon these schools in their time of financial plight because a loss will not only be to those schools, but to the country.

Mr. STOKES. Thank you very much, Mr. Chairman.

Mr. WAXMAN. We are pleased to have you with us. We have your complete statement, which will be made a part of the record. We would appreciate it very much if you would summarize in 5 minutes, so we could have an opportunity to question you.

STATEMENT OF RALPH H. HINES, PH. D., ON BEHALF OF CONSORTIUM OF MINORITY HEALTH PROFESSIONS SCHOOLS, ACCOMPANIED BY WALTER C. BOWIE, D.V.M., PH. D.

Dr. HINES. Thank you very much, Mr. Chairman, members of the committee.

I am Ralph Hines, executive vice president and provost, Meharry Medical College, Nashville, Tenn. Accompanying me is Dr. Walter Bowie, dean, School of Veterinary Medicine, Tuskegee Institute, Tuskegee, Ala.

I will summarize and not read the complete statement, Mr. Chairman, in order to stay within the 5-minute rule. [See p. 197.]

With the passage of the Health Professions Educational Assistance Act of 1963, Congress declared that the availability of high quality health care to all Americans is a national goal. Congress declared that health professions personnel are a national resource and that it is therefore appropriate to provide support for the education and training of such personnel. We seek to reach this national goal through a partnership between the Federal Government and the health professions schools, in order to correct problems of geographic maldistribution, underrepresentation of minorities and women, and the need for health professionals trained in primary care.

In concert with the commitment of the Congress that the health care system provide all Americans equal access to health care, the members of the Consortium of Minority Health Professions Schools wish to highlight the contributions of our institutions in the training of health professionals for poor and disadvantaged communities. Significant numbers of our graduates provide health services to communities with large numbers of persons who are socially and economically disadvantaged. However, much remains to be done. For example, while blacks comprise almost 12 percent of the U.S. population, blacks only represent 1.7 percent of the physicians, 1.8 percent of the dentists, 2 percent of the pharmacists, and 0.7 percent of the veterinarians in this country. Similar deficiencies exist for other minority health professionals. The critical need for more minority health professionals is apparent.

Support from the Federal Government in the form of capitation and special project grants, has been given to increase the number of physicians in the United States. Health professions schools have responded by doubling the number of physicians trained annually.

Although it has been projected that the United States may have an adequate number of physicians by 1990, serious deficiencies remain in health manpower in many areas of the country.

Some 40 million of our citizens still live in areas officially recognized as medically underserved. A shortage of primary care physicians exists both in the inner cities and our urban areas. Federal support is therefore needed to address these national needs.

Institutional support is an investment by the Nation to enable institutions to maintain high standards. This investment is returned to the Nation in the form of uniquely qualified health professionals to meet the following national needs:

One: More individuals from underrepresented minorities.

Two: More individuals from socioeconomically and educationally disadvantaged backgrounds.

Three: More women for health professions careers.

Four: A higher percentage of graduating medical students in family medicine residencies.

Five: Recruitment of students from health manpower shortage areas.

Six: Education in nutrition, geriatrics, preventive medicine and cost containment.

From the schools of the consortium, 50 percent of the black pharamacists in the United States have graduated; 90 percent of all black veterinarians in the United States have graduated from Tuskegee Institute School of Veterinary Medicine; and 43 percent of all black physicians and dentists in the United States were graduated from Meharry Medical College in Nashville; and 76 percent of the graduates of Meharry Medical College are engaged in primary care.

It is critical that the capacity of our institution be strengthened through new legislation, to educate and train the appropriate kinds of physicians, dentists, pharmacists and veterinarians needed by the Nation.

The training by our institutions of the new kinds of health professionals, needed by our Nation, can be maintained if the new legislation authorized support for institutions which would enhance their capability to meet the Nation's health manpower needs, including the need for primary care physicians in underserved rural and urban communities.

Through a joint venture with the Federal Government, we seek an investment to help us train the kinds of physicians needed for the 1980's. This joint venture would signal a national commitment to adequate health care for all Americans, and access to a career in the health professions for all of our youth.

Present data indicate a dilemma for the Nation to overcome deficiencies in minority health professions manpower. While there is an alleged oversupply of nonminority health professionals, there is no oversupply of minority health professionals. Rather, there is a serious deficiency of minority health professionals, which represents a national crisis.

Mr. Chairman, we respectfully urge the committee to amend section 211 of H.R. 6802 in order to divide it, therefore, into two parts. We recommend the first part be enacted as it is presently proposed and in the same language and style except that the amount of the authorization be reduced by one-half in each subsection of (D), the authorization appropriation.

We further recommend and urge the committee to create a new subsection of 211 which would use the remaining amount proposed for section 211 for those schools who might wish to participate in special programs and projects to carry out and to achieve certain identifiable national purposes and goals.

Among these goals which have been highlighted in numerous congressional and administrative findings, the following are in the national interest; to promote an increase in primary care; that is, family medicine, internal, and pediatric; two, to insure an increase of minority participation in the health profession; three, to assure the availability of health professionals in medically underserved areas by increasing the number of first-year students from health manpower shortage areas; four, to assure an increase of women in the health professions.

We believe that the adoption of these special project purposes and their inclusion in the bill would in no way infringe upon an institution's right to choose to participate or not participate in these federally designated objectives. The need for more work to be done in these areas is critical for the Nation as a whole.

It is further recommended that the committee authorize the remaining one-half of the proposed amount in each subsection by each discipline in the same proportion for each year of the bill's intended period of authorization.

The section of H.R. 6802 which deals with startup, financial distress, interdisciplinary training and curriculum grants—section 121—gives us cause for grave concern. This is a most critical section, affecting the survival of our institutions and the maintenance of quality educational programs.

Each of us has participated in the health manpower program since its inception in 1963. We are in financial distress now, and will be in financial distress in the future unless significant help is acquired. With mounting inflation, there is increased necessity to maintain and to improve our educational base in order to remain accredited institutions; and, in view of higher expectations and demands among minorities and the disadvantaged for access to health professions careers, we find ourselves in the untenable position in which income from traditional sources is simply not sufficient.

Our situation is critical. The support of the Federal Government in these institutions is a good investment to meet a national need.

We commend and applaud the subcommittee's recognition and support of the concept of financial distress programs to assist institutions in danger of loss of accreditation or subversion of quality educational programs. We applaud Mr. Tim Lee Carter's amendment to support this section and urge the committee adopt the increased recommendation of $25 million for this period and for the succeeding 4 years.

We request two actions of the committee: That specificity be given to the amount authorized for each segment of section 121; and that substitute language be inserted to recognize two levels of financial distress of various institutions and to deal with these needs differentially. We submit to the committee the specific language we would wish to be adopted.

Mr. Chairman, we are concerned about the increasing number of low- and middle-income students who cannot afford a health sciences education. We have historically sought out and encouraged young people to develop their talents and to acquire needed skills. These skills are being used to improve the quality of life for all Americans. Yet, the economics of the 1980's could force our institutions to seek only those students who could afford to pay from their own resources for graduate and professional education. Therefore, we support a student financial assistance program that would maintain the democratic concept of choice.

Given the financial need profiles of students enrolled in the institutions of our consortium, an effective student assistance program is needed. We support the national health service scholarship program and urge its continuation.

We urge that the exceptional financial need scholarship program to be extended to include second-year students in addition to first-year students.

We recommend that interest subsidies be provided for loans to needy students in order that these students have a more reasonable fixed financial liability.

New health manpower legislation should insure that the health careers opportunity program is upgraded and expanded.

In the past, the Congress has authorized grants for the construction of new facilities at health professions schools. It is now believed that the need for additional health manpower has been met and thus, additional facilities are not needed. However, for minorities, the facts do not support this belief.

We recommend that the subcommittee add a section to H.R. 6802 for the construction of new medical education facilities, and the language is included in the longer text of this testimony.

To develop educational programs of quality in the health sciences, it is essential that clinical experiences be provided. Since 1973, the Liaison Committee on Medical Education—LCME—has required, as a condition for accreditation, that new 2-year schools develop into M.D. degree granting institutions.

Conversion support would assist the School of Medicine at Morehouse College in its plan to develop into a 4-year, M.D.-degree-granting institution.

We recommend to the subcommittee the authorization of conversion support for new 2-year schools of medicine to help them meet the requirement of the LCME that they become a M.D.-degree-granting institution. Language is suggested for that change.

Conversion assistance from the Federal Government has been established in previous health manpower bills, and has supported the conversion of 2-year schools to degree-granting institutions.

In summary, we urge the following:

One: The enactment of authority for institutional support to assist health professional schools meet national priority needs.

Two: That "financial distress grants" be enacted with substitute language as recommended in this testimony.

Three: The enactment of the student assistance provisions.

Four: The enactment of an improved health careers opportunity program.

Five: The inclusion of an authority for construction grants for existing new 2-year schools of medicine.

Six: The inclusion of an authority for "conversion projects" to assist new 2-year schools to develop into degree-granting programs, as required for continued accreditation.

We thank you for the opportunity to present to this committee vital issues concerning the health manpower needs of the Nation. These legislative measures proposed and/or supported by the Consortium of Minority Health Professions Schools, if enacted, will enable our institutions to continue their service to the Nation, in meeting national priority needs.

[Testimony resumes on p. 211.]

[Consortium of Minority Health Professions Schools prepared statement follows:]

Testimony on the Health Professions Educational Assistance and Nurse Training Amendments of 1980 (HR 6802)

Submitted to the Subcommittee on Health and the Environment
of the
Committee on Interstate and Foreign Commerce
United States House of Representatives

by

The Consortium of Minority Health Professions Schools

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Patrick Wells, Ph.D., Dean

March 21, 1980 Washington, D.C.

Chairman Waxman and members of the Committee, I am Ralph H. Hines, Executive Vice President and Provost, Meharry Medical College, Nashville, Tennessee. Accompanying me at the table is Dr. Walter C. Bowie, Dean, School of Veterinary Medicine, Tuskegee Institute, Tuskegee Institute, Alabama. We are representing the Consortium of Minority Health Professions Schools, which includes the Charles R. Drew Post Graduate Medical College; the School of Medicine at Morehouse College; Tuskegee Institute School of Veterinary Medicine; Florida A & M University School of Pharmacy; Meharry Medical College; Texas Southern University School of Pharmacy; and Xavier University College of Pharmacy.

A. Institutional Support

With the passage of the Health Professions Educational Assistance Act of 1963, Congress declared that the availability of high quality health care to all Americans is a national goal. Congress declared that health professions personnel are a national resource and that it is therefore appropriate to provide support for the education and training of such personnel. We seek to reach this national goal through a partnership between the federal government and the health professions schools, in order to correct problems of geographic maldistribution, underrepresentation of minorities and women, and the need for health professionals trained in primary care.

In concert with the commitment of the Congress that the health care system provide all Americans equal access to health care, the members of the Consortium of Minority Health Professions Schools wish to highlight the contributions of our institutions in the training of health professionals for poor and disadvantaged communities. Significant numbers of our graduates provide health services to communities with large numbers of persons who are socially and economically disadvantaged. However, much remains to be done. For example, while blacks comprise almost 12 per cent of the U.S. population, blacks only represent 1.7 per cent of the physicians, 1.8 per cent of the dentists, 2.0 per cent of the pharmacists and 0.7 per cent of the veterinarians in this country. Similar deficiencies exist for other minority health professionals. The critical need for more minority health professionals is apparent.

Support from the federal government in the form of capitation and special project grants, has been given to increase the number of physicians in the United States. Health professions schools have responded by doubling the number of physicians trained annually.

Although it has been projected that the United States may have an adequate number of physicians by 1990, serious deficiencies remain in health manpower in many areas of the country.

Some 40 million of our citizens still live in areas officially recognized as medically underserved. A shortage of primary care physicians exists both in the inner cities and our urban areas. Federal support is therefore needed to address these national needs.

Institutional support is an investment by the nation to enable institutions to maintain high standards. This investment is returned to the nation in the form of uniquely qualified health professionals to meet the following national needs:

1. More individuals from underrepresented minorities
2. More individuals from socioeconomically and educationally disadvantaged backgrounds
3. More women for health professions careers
4. A higher percentage of graduating medical students in family medicine residencies
5. Recruitment of students from health manpower shortage areas
6. Education in nutrition, geriatrics, preventive medicine and cost containment.

From the schools of the Consortium, 50 per cent of the black pharmacists in the U.S. have graduated, 90 per cent of all black veterinarians in the U.S. have graduated (from Tuskegee Institute School of Veterinary Medicine) and 43 per cent of all black physicians and dentists in the United States were graduated from Meharry Medical College (and 76 per cent of the graduates of Meharry Medical College are engaged in primary care.)

It is critical that the capacity of our institutions be strengthened through new legislation, to educate and train the appropriate kinds of physicians, dentists, pharmacists and veterinarians needed by the nation.

The training by our institutions of the new kinds of health professionals, needed by our nation can be maintained if the new legislation authorized support for institutions which would enhance their capability to meet the nation's health manpower needs, including the need for primary care physicians in underserved rural and urban communities.

Through a joint venture with the federal government we seek an investment to help us train the kinds of physicians needed for the 1980's. This joint venture would signal a national commitment to adequate health care for all Americans, and access to a career in the health professions for all of our youth.

Present data indicate a dilemma for the national to overcome deficiences in minority health professions manpower, while there is an alleged oversupply of non-minority health professionals. There is no oversupply of minority health professionals. Rather, there is a serious deficiency of minority health professionals, which represents a national crisis.

The facts are contained in the following tables.

TABLE I

BLACK ENROLLMENT IN FIRST - YEAR CLASSES IN U.S. MEDICAL SCHOOLS (1971-1978)

YEAR	NUMBER AND PERCENT OF ENROLLMENT		TOTAL FIRST YEAR ENROLLMENT
1971-72	882	7.1	12,361
1972-73	957	7.0	13,677
1973-74	1,027	7.3	14,154
1974-75	1;106	7.5	14,763
1975-76	1,036	6.8	15,295
1976-77	1,040	6.7	15,613
1977-78	1,085	6.7	16,136
1978-79	1,061	6.4	16,501

SOURCE: DATA FROM PUBLICATIONS OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES, ONE DUPONT CIRCLE, WASHINGTON, D.C. 20036

Poor and disadvantaged Americans, including our minority citizens, should not have their legitimate and serious needs for more health professionals submerged in the controversy concerning the overall health manpower projections of the Department of Health and Human Services (DHSS).

Health manpower shortages in poor and disadvantaged communities have contributed to an array of serious health problems in our rural and city communities of the nation: for example, a shortened life expectancy for blacks (some 6-8 years less than for whites); higher infant mortality rates; a twofold greater incidence of high blood pressure; and many other alarming statistics.

The institutions of the Consortium are working diligently to supply needed health manpower for our nation.

A fraction of the graduates of all health professions schools go into underserved areas and into primary care careers.

We therefore propose that all health professions schools receive institutional

TABLE II

MINORITY STUDENTS IN FIRST YEAR OF DENTAL SCHOOL

ACADEMIC YEARS 1971-72 THROUGH 1978-79 1/

Academic year	Total first year students	Black	American Indian	Racial/ethnic category Mexican-American	Puerto Rican	Oriental (Asians)	Other Minority	Total Minority	Percentage minority of total first-year Students
1971-72	4,705	245(5.2%)	4	27	13	112(2.4%)	11	412	8.8
1972-73	5,287	266(5.0%)	5	53	3	138(2.6%)	10	475	9.0
1973-74	5,389	273(5.3%)	12	64	5	141(2.6%)	34	529	9.8
1974-75	5,555	279(5.2%)	12	68	7	14[illegible](2.5%)	43	551	9.9
1975-76	5,697	298(5.2%)	22	64	11	186(3.2%)	56	637	11.2
1976-77	5,869	291(5.0%)	21	81	15	174(3.0%)	68	650	11.1
1977-78	5,390	296(5.0%)	10	2/	2/	225(3.8%)	2/	641	10.9
1978-79	6,301	280(4.4%)	15	122*		263(4.2%)		681	10.8

1/ Excludes University of Puerto Rico.

2/ The data for 1977-78 differ from earlier years because of changes in racial/ethnic categories used for data collection. In 1977-78 there were 110 first-year students under a new category "Hispanic". Also, the former category for "Other minority" was eliminated.

* Hispanic including Puerto Ricans in U. S. Schools.

NB Blacks = 11.6% of total U.S. population. Hispanics - 5.6% and Asians (all types) = 0.9%

SOURCE: AMERICAN DENTAL ASSOCIATION, COUNCIL ON DENTAL EDUCATION. MINORITY STUDENT ENROLLMENT AND OPPORTUNITIES IN U.S. DENTAL SCHOOLS, FOR 1971-72 AND FOR 1972-73. MINORITY REPORT; SUPPLEMENT OF ANNUAL REPORT ON DENTAL EDUCATION 1973-74, AND REPORTS FOR SUBSEQUENT ACADEMIC YEARS. CENSUS OF POPULATION PART I, U.S. SUMMARY 1970. BUREAU OF THE CENSUS POPULATION PROFILE OF THE UNITED STATES: 1978.

TABLE III

Minority Undergraduate Enrollment in Schools and Colleges of Pharmacy

Academic Years 1971-1972 through 1978-1979

Racial/Ethnic Category

Academic Year	Total Enrollment	White Americans	%	Blacks	%	*	Hispanics	%	Native Americans	%	Asian Ancestary	%	Foreign	%
1971-1972	16,476	14,831	90.0	618	3.7	--	203	1.2	8	.04	816	4.9	--	--
1972-1973	18,445	16,295	88.3	659	3.6	372	254	1.37	29	0.1	720	3.9	483	2.6
1973-1974	20,830	18,358	88.1	619	3.0	314	343	1.7	25	0.1	697	3.3	788	3.7
1974-1975	22,688	19,899	87.7	727	3.2	377	278	1.2	32	0.1	690	3.0	1,062	4.6
1975-1976	23,836	20,741	87.0	915	3.8	470	359	1.5	36	0.2	799	3.2	1,006	4.3
1976-1977	23,465	20,552	87.5	938	4.0	481	353	1.5	37	0.2	761	3.2	824	3.5
1977-1978	23,273	20,271	87.1	984	4.2	533	360	1.5	39	0.2	809	3.4	810	3.5
1978-1979	23,078	20.108	87.1	942	4.1	457	376	1.6	34	0.1	911	3.4	707	3.1

Source: American Journal of Pharmacy Education 1979

*Total number enrolled in the traditionally black colleges and Schools of Pharmacy

TABLE IV

NATIONAL MINORITY HEALTH PROFESSIONALS

HEALTH PROFESSIONAL	TOTAL	BLACK%	PARITY	NEEDED/%	BLACK/BLACK POPULATION	WHITE/WHITE POPULATION
Physicians	348,443	6,106/1.7	41,813	35,707/10.3	1:4,001	1:540
Dentists	112,000	2,098/1.8	13,440	11,342/10.2	1:13,294	1:1,684
Optometrists	24,242	186/0.7	2,909	2,723/11.3	1:49,951	1:7,695
Pharmacists	122,500	2,501/2.0	14,700	12,199/10.0	1:11,151	1:1,542
Podiatrists	8,000	250/3.1	960	710/8.9	1:111,564	1:23,889
Osteopaths	15,000	250/1.6	1,800	1,550/10.4	1:111,564	1:12,551
Veterinarians	36,000	252/0.7	4,320	4,068/11.3	1:110,678	1:5,179

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DATA FROM: MINORITIES AND WOMEN IN THE HEALTH FIELDS, SEPTEMBER, 1975; HEALTH MANPOWER REFERENCES: AND HEALTH RESOURCES AND UTILIZATION STATISTICS 1976; NATIONAL CENTER FOR HEALTH STATISTICS: A REPORT TO THE PRESIDENT AND CONGRESS ON THE STATUS OF HEALTH PROFESSIONS PERSONNEL IN THE U. S., 1978.

support, based upon a percentage of the cost of education in that particular health profession.

We further propose that incentive awards be given to health professions schools which respond specifically to identified national priority needs, as listed above.

B. Financial Distress Grants

Mr. Chairman, the section of HR 6802 which deals with Start-up, Financial Distress, Interdisciplinary Training and Curriculum Grants (Section 121) gives us cause for grave concern. This is a most critical section, affecting the survival of our institutions and the maintenance of quality educational programs.

Each of us has participated in the Health Manpower Program since its inception in 1963. We are in financial distress now, and will be in financial distress in the future, unless significant help is acquired. With mounting inflation, there is increased necessity to maintain and to improve our educational base in order to remain accredited institutions; and, in view of higher expectations and demands among minorities and the disadvantaged for access to health professions careers, we find ourselves in the untenable position in which income from traditional sources (tuition, endowment, fund-raising, etc) is simply not sufficient. Reduced funding and rising costs have created financial hardships which none of us can fend off. We have addressed these issues to the various constituencies who have traditionally supported us: alumni, state legislatures and the general public, through fund-raising programs. They have each responded in significant measure but more needs to be done.

Our situation is critical!

The support of the federal government in these institutions is a good investment to meet a national need.

We commend and applaud the Subcommittee's recognition and support of the concept of financial distress programs to assist institutions in danger of loss of accreditation or subversion of quality educational programs.

We recommend two actions:

1. That specificity be given to the amount authorized for each segment of Section 121;
2. That substitute language be inserted to recognize two levels of financial distess of various institutions and to deal with these needs differentially.

We therefore request that the Committee amend this section to read:

> "The Secretary may make grants to, and enter into contracts with schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy and podiatry that are in serious financial distress for purposes of assisting such schools to
>
> 1. Meet the cost of operation
> 2. Meet applicable accreditation requirements if such a school has a special need to be assisted in meeting such a requirement, or
> 3. Carry out appropriate opertational, managerial and financial reforms.
>
> In addition, the Secretary may enter into cooperative agreements for not more than five years with schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, and podiatry, for the purposes of meeting the costs of operation and of appropriate operational, managerial and financial reform if such school is in serious financial distress and has previously received grants support under Section 788(b) (as it existed prior to October 1, 1980). Such a school must submit to the Secretary a plan providing for the school to achieve financial solvency within five years and has agreed to carry out such a plan.
>
> For the purpose of making grants and entering into contracts to carry out the financial distress activities of this section, there are authorized to be appropriated $15,000,000 for the fiscal year ending September 30, 1981 and $20,000,000 for the succeeding four fiscal years.
>
> For the purposes of making grants to carry out the start-up activities of this section, there are authorized to be appropriated $5,000,000; for interdisciplinary training, $2,000,000; and for curriculum grants $2,000,000; for the fiscal year ending September 30, 1981 and for each of the succeeding two years".

C. Student Assistance

Mr. Chairman, we are concerned about the increasing number of low and middle income students who cannot afford a health sciences education. We have historically sought out and encouraged young people to develop their talents and to acquire needed skills. These skills are being used to improve the quality of life for all Americans. Yet, the economics of the 1980s could force our institutions to seek only those students who could afford to pay from their own resources for graduate and professional education. Therefore, we support a student financial assistance program that would maintain the democratic concept of choice.

A student financial need profile was presented by member institutions of the Consortium to the Subcommittee on Health and the Environment of the House Committee on Interstate and Foreign Commerce, Houston, Texas, October 5, 1979. The student financial need profile reflects the following:

> Meharry Medical College - "In keeping with this historic and unique mission the college enrolls more disadvantaged students than any other medical school in the United States. Some 86 percent of our student body requests and receives financial aid to help them pay tuition and other expenses."
>
> School of Medicine at Morehouse College - "Seventeen of the students in the Charter Class (24 students) are recipients of National Health Service Corp Scholarships, one is the recipient of an Exceptional Need Scholarship, another is the recipient of an Armed Forces Health Professions Scholarship. Three of the remaining students have received scholarships and loans from various private sources, including medical school funds."
>
> Xavier University of Louisiana School of Pharmacy - "Our current tuition rate of $2,400 per year is well below the national average of $3,100 for private schools of pharmacy, but the economic status of our students is proportionately far lower than that of their peers in other institutions.

Given the financial need profiles of students enrolled in the institutions of our Consortium, an effective student assistance program is needed. We support the National Health Service Scholarship Program and urge its continuation.

We urge that the Exceptional Financial Need Scholarship program to be extended to include second year students in addition to first year students.

We recommend that interest subsidies be provided for loans to needy students in order that these students have a more reasonable fixed financial liability.

D. The Health Careers Opportunity Program (HCOP)

New Health Manpower legislation should insure that the Health Careers Opportunity Program is upgraded and expanded. This program is a significant vehicle through which federal grants and contracts are made to health professions schools to assist young people who are socially, economically, and educationally disadvantaged enter the health professions.

In addition to the on-going commitment of those institutions that have traditionally perpared disadvantaged students for careers in the health professions, there is increasing interest by many other instituions and community-based organizations in developing programs to identify, recruit and retain disadvantaged students.

The focus of these programs is being broadened to more fully serve native Americans, in addition to blacks, Hispanics and other disadvantaged persons.

The Consortium believes, however, 80% of these grants be awarded to degree-granting institutions. These institutions have proven that they can carry out the HCOP mission in a more cost-effective manner.

For this program, we recommend authorizations of $40,000,000 for FY 81, $44,000,000 for FY 82 and $48,000,000 for FY 83.

E. Facilities

In the past, the Congress has authorized grants for the construction of new facilities at health professions schools. It is now believed that the need for additional health manpower has been met and thus, additional facilities are not needed. However, for minorities, the facts do not support this belief. Tables I, II, III indicate that the goals for the development of minority health manpower have not been met. In order that the institutions in the Consortium for Minority Health Professions Schools obtain and maintain their accreditation, facilities of acceptable standards must be constructed. Funds for facilities at these new and developing institutions are needed.

We recommend that the Subcommittee add a section to HR 6802 for the construction of new medical education facilities. The suggested language for these sections:

> "The Secretary may make grants to a school to assist in:
>
> 1. the construction of facilities for use in the training and research activities of allopathic physicians, osteopathic physicians, dentists, veterinarians, optometrists, podiatrists, pharmacists, and professional public health personnel if, in the fiscal year ending September 30, 1978 or thereafter such school received or was eligible to receive start up assistance grants under either section 788 (g) (as it existed prior to October 1, 1980) or under section 713(a) (as it existed on October 1, 1980).
> 2. for grants under this section there is authorized to be appropriated $10,000,000 for the fiscal year ending September 30, 1981 and for each of the succeeding three fiscal years.
> 3. in considering applications for grants under this section the Secretary shall give just consideration to applications submitted by medical schools for the expansion of a two-year program to a degree granting program and by new schools that anticipate a high percentage of minority students."

F. Conversion Projects

To develop educational programs of quality in the health sciences, it is essential that clinical experiences be provided. Since 1973, the Liaison Committee on Medical Education (LCME) has required, as a condition for accreditation, that new two year schools develop into M.D. degree granting institutions.

Conversion support would assist the School of Medicine at Morehouse College in its plan to develop into a four year, M.D. degree granting institution.

We recommend to the Subcommittee the authorization of conversion support for new two year schools of medicine to help them meet the requirement of the LCME that they become a M.D. degree granting institution. Language suggested for these sections follows:

> "The Secretary may make a single grant to a public or non-profit private two year school of medicine that intends to become a school accredited to grant the degree of doctor of medicine. The amount of the grant to a school under this section shall be equal to the product of $50,000 and the number of third year students that will be initially enrolled in such school. No school may receive more than one grant under this section."
>
> "Upon request of a school, a grant received under this section may be used in the year preceding the initial enrollment of third year students in such school."

Conversion assistance from the Federal Government has been established in previous health manpower bills, and has supported the conversion of two year schools to degree granting institutions.

In summary, we urge the following:

1. The enactment of authority for institutional support to assist health professional schools meet national priority needs.
2. That "Financial Distress Grants" be enacted with substitute language as recommended in this testimony.
3. The enactment of the student assistance provisions.
4. The enactment of an improved Health Careers Opportunity Program.
5. The inclusion of an authority for construction grants for existing new two year schools of medicine.
6. The inclusion of an authority for "Conversion Projects" to assist new two year schools to develop into degree granting programs, as required for continued accreditation.

We thank you for the opportunity to present to this Committee vital issues concerning the health manpower needs of the nation. These legislative measures proposed and/or supported by the Consortium of Minority Health Professions Schools, if enacted, will enable our institutions to continue their service to the nation, in meeting national priority needs.

Respectfully submitted,

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College of Pharmacy, Texas Southern University

Mr. **Waxman**. Thank you very much, for your testimony.

What are the reasons for the existing financial distress of the health institutions in the consortium, and what can be done after your requested 5 years of Federal assistance to assure financial viability and stability?

Dr. **Hines**. We believe, Mr. Chairman, that it will require 5 years of assistance for us in order to reach a point of viability. In the interim, a good deal and good many things can be done to improve the financial base upon which the schools of this consortium operate.

We will undertake many measures ourselves through public fundraising, through reorganization programs, through a variety of activities that are available to us to improve our own condition. However, it will require time to do so.

We have seen many, many years of benign neglect, if you will, of trying to get into the mainstream, which has caused us serious financial difficulty which we could not overcome because of the limitation of our student consistency and their inability to support us, our alumni's inability to support us, and because we have no connections to State largesse which other institutions may have available to them.

Mr. **Waxman**. What is the status of the various accreditations of the schools involved in the consortium and other schools that might well be entitled to assistance. What is the quality of medical education provided at these institutions?

Dr. **Hines**. All of our institutions are accredited, but, again, the provisions of the various accrediting agencies have been made stronger, and there has been a greater insistence upon upgrading the quality of educational programs in our institutions in order to remain accredited. As standards are improved, unless we are able to cope with them financially and deal with them in terms of cost, the loss of accreditation is imminent.

Mr. **Waxman**. Why would the loss of accreditation be imminent? Wouldn't it be because of financial problems or other problems?

Dr. **Hines**. Because of financial problems and our inability to meet the higher standards of the newer requirements without the financial base to cover them.

Mr. **Waxman**. What is your evaluation of the quality of the students that have been going to the distressed medical schools over the last several years? Are you losing some of your best students from previous years to other institutions now that we hopefully are seeing some greater integration in the leading medical schools of the country?

Dr. **Hines**. As a matter of fact, Mr. Chairman, we have noted over the last 10 years that the quality of our students has significantly improved rather than seeing any decline in that quality. We see students doing much better on the admissions tests; we see students scoring much higher on general aptitude levels; and we have seen general improvement in the student body. This is not to say there is still not a good deal more to be done, but because of opening opportunities I don't believe there has been a diminution of the quality of students applying to our minority institutions.

Mr. **Waxman**. Thank you very much.

Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

Mr. Chairman, I have a short statement, if you will permit me.

The witnesses today will be addressing two issues of particular importance in our discussion of the health professions education programs: nurse training and minority health profession education. As I have indicated previously, it is my view that we don't have a sufficient supply of nurses nationwide. I am especially concerned about the reported drop in applications and the decline in the number of graduates from basic nurse education programs. I am looking forward to hearing from our witnesses as to the most appropriate role of the Federal Government in addressing these concerns. Second, I am concerned about the need to maintain the viability of our minority health professions educational institutions. These schools, represented by our witnesses today, constitute a national resource, since they educate professionals not only for their particular areas, but for the Nation at large.

As I indicated yesterday, I have introduced legislation that offers one approach to strengthen these institutions which would increase the funding for financial distress grants to $25 million from the current ceiling of $10 million. However, to solve this problem for the long term, we must find ways to strengthen the fiscal management and planning capability of these institutions.

I have some questions now, if I might, Mr. Chairman.

I will be brief.

As you know, the exceptional financial needs scholarship program provides funds to first-year students in exceptional need, with priority being given to students in medicine, osteopathy and dentistry. According to figures I have for 1979, the schools identified in excess of 1,350 eligible students. To award funds to all these students would have required $15 million, but only $7 million was appropriated that year. If the need continues to remain so great, how can we best address the needs of these students, given the limited resources available?

Dr. HINES. I would like to ask my colleague, Dr. Bowie, to respond to that question.

Dr. BOWIE. Mr. Carter, I think you have raised a very appropriate question. It is one that we obviously have expressed some real concern about for some period of time.

I think the question that we are dealing with is one in which we should be looking at ways in which we can increase the numbers of underrepresented students who gain access to the health professions, and I think this question is a multifaceted question.

I think there are ways in which we can do a better job of recruiting these students. We know that there is a problem in terms of role models in the community so these students understand and appreciate these are fields that they also should have a chance to attend.

There is the need to deal with the whole question of counseling. The counseling services should really begin back at the junior high school level and come through the high school levels. We are going to have to provide additional funding, as I see it, adequate support to those specific programs that are designed to attract and provide entry into the health professions of these students. We have to deal in many instances with some preliminary educational reinforcement needs of these students.

As I mentioned, we also need counseling, not only at the junior high and high school level, but also at the college level, and even into the professional schools. We find many of the academic problems that surface for these students have personal problems as their base, and, therefore, the need for counseling even in the professional schools is clear.

If you look again at H.R. 6802, the authorization level for exceptional financial needs for our scholarship program is only $12 million; $14 million for 1982; $16 million for 1983. This simply, in my opinion, is not enough money. The present level in the fiscal year 1981 budget of the administration for this category is $10 million. That is the appropriation level, so there is a real concern there as to whether or not we are really losing ground.

The HCOP programs, as you well know, have been extremely helpful. I think there are a number of incentive reimbursement awards programs that we can provide which will try to encourage other institutions, not just the minority institutions, but the majority institutions as well, to become much more active in dealing with this problem.

I think we have to deal with the development of special kinds of faculty and staff to deal with this problem. I think we can look very carefully at the ways in which we are now admitting our students, our admissions process. I think we should have some special educational incentive approaches, special project grants, if you will, for serving the underserved students to get more of those students in the inner cities and from the rural areas, and we need to look at the admissions process to see to what extent we can modify the admissions process so that it will, in fact, encourage those students to come into these programs.

This is to suggest that if these students come from these areas, there may well be more likelihood that they may well return to these areas. So I think the admissions process is a way in which we have to look at this.

I don't believe the schools have really looked at it as carefully as they should. The HCOP programs, as you know, are at a level of $22 million. That is in the fiscal year 1981 budget. In H.R. 6802, the recommendation of the authorization level begins at $25 million for the first year, $27.5 million, and then $30 million. We already are at an appropriation level of $22 million, so here again I am suggesting that these programs are totally underfunded.

The figures that came out of the House report last June would suggest that we only are reaching 20,000 students with the HCOP programs. That is not a large enough pool that we should be dealing with.

So, Dr. Carter, I think your question is very germane, and I think there are many things we have not done which we can do to deal with this problem.

Mr. **Carter**. The bill I introduced yesterday provides a multigrant authority with advanced funding so the schools would not have to reapply each year. This is for minority schools, as you know. Will you comment on the advantages and disadvantages of this approach?

Dr. **Hines**. I think I will comment, Mr. Carter. I think that is a very important provision.

One of the problems in the passage of the financial distress grants has been because it was a reimbursement-type program; schools found themselves in greater financial distress at the end of the year than they were at the beginning of the year, simply because there was not advanced funding; there was not the possibility of planning ahead. One had to borrow money in order to stay alive, which meant paying an interest cost on top of the predictable deficit that one would have.

This provision, I think, would greatly alleviate a problem and would greatly allow the opportunity of enough forward planning that financial distress could be relieved.

I appreciate that suggestion and that portion of the bill which takes this thoughtful approach to helping to solve the problem.

Mr. **Carter**. You indicate that your institution has the highest percentage of graduates working among the Nation's urban and rural poor. I want to congratulate you on that, gentleman. And your testimony indicated also that Tennessee is prohibited by State constitutional law from providing direct support to private or parochial institutions. How many other health professionals schools are affected by such State laws? Do you know?

Dr. **Hines**. I believe the State of Texas prohibits the same sort of thing. Of the States involved, Alabama, has an indirect prohibition which would not allow them to be given State aid under any kind of direct formula for which the proposals which we have heard for increasing our funding through State appropriations does not provide an adequate answer.

Mr. **Carter**. Thank you very kindly. Meharry is only 95 miles south of where I live, so I have a vested interest.

Thank you, Mr. Chairman.

Mr. **Waxman**. Thank you, Dr. Carter.

Mr. Leland?

Mr. **Leland**. I have a special interest in what you guys are up to for obvious reasons. I would like to just ask a couple of questions. One is, while you have referred to minority schools and your interests in minority schools, you have not been very specific.

Do you admit to your Minority Health Profession Schools students other than minority students?

Dr. **Hines**. Yes, we do. The emphasis in the admissions process at our institutions has generally been to admit students from disadvantaged backgrounds. While the majority of the students at our institutions are minority students, all of our institutions are concerned about those students who come from areas of great need, and who come from disadvantaged backgrounds, educational and economic. So, consequently, the admission and the goals and purposes to which we address ourselves is a broader concern. It happens that the majority of persons involved are minorities, but there is no exclusivity to poverty; there is no exclusivity to being in need, and our institutions have been addressing ourselves to people who are in need regardless of their race.

Mr. **Leland**. I was an intern in clinical pharmacy at Texas Southern University School of Pharmacy. We had to have remedial programs in the school of pharmacy there because of the problems that were experienced by the students who had come to the school of pharmacy in their public school educational backgrounds.

I understand that you have done basically the same thing, but you would like to do more of that.

What makes a minority institution or a large black institution special compared to the other institutions that admit minority institutions other than just the fact that these institutions are run by black people or Mexican American people, or other minorities?

Dr. **Bowie**. I think we are dealing with two things, Mr. Leland. I think the environment is very important for these students. These students feel that they are wanted at these institutions.

I think the second thing that is very important is the commitment on the part of the faculty and the staff to deal with the special needs of these students. I know that my faculty spends untold hours in tutorials, in special kinds of reinforcement efforts which really are above and beyond the call of duty. That is what is required to deal with these students.

These students, first of all, must feel that they are wanted in the programs; they must feel there is someone there who is concerned about their needs and attempts to address those needs, and there must be a commitment clearly on the part of the faculty and the staff to deal with the special needs of these students.

Mr. **Leland**. In that case, how competitive are your students once they graduate with the rest of the professionals who graduated with the same degrees and supposedly the same certifications in any given State?

Dr. **Bowie**. Let me just cite the statistics for the school of veterinary medicine, and I am sure there are similar ones for the other schools we represent.

We have shown on the veterinary aptitude test, which is the equivalent of the MCAT, that our students, as a whole, fall below the 30th percentile upon admission to the program. On the other hand, at the end of the period of training, we have clear-cut evidence that these students are above the national average, and these are on State board examinations, on USDA accreditation examinations and other measures, to determine the level at which these students are finishing the program.

I could give you the data and would be willing to submit it to the record. There is no question in my mind that we are able to take these students at a level where, in many instances, they may not gain access to other schools, but, on the other hand, the evidence is clear that with the kinds of programs that we have, we are able to work with these students, and these students are graduating at a level that they clearly are competent professionals.

Dr. **Hines**. I would echo the same response, Mr. Leland. It is a requirement of our institutions that the students pass the national boards, parts 1 and 2, before they graduate, the same boards as administered and given in schools across the country nationwide, and it is the same national boards for which the licensing procedures take place. Without that competence, the students cannot enter his profession.

By the time he finishes the education program at an institution in our consortium, he is as qualified as any other student.

Mr. **Leland**. You have taken a student who is probably disadvantaged because of the environment he or she grew up in, a poor community with probably a poor family background not in terms of the quality of the family, itself, but in terms of the family not necessarily having the educational background to help to supplement the student's educational process when he or she goes home from public school in the evenings. You have molded that person into a person who can graduate from an institution like yours, and compete as well as anybody else, if not better?

Dr. **Hines**. That is exactly right.

Mr. **Leland**. I thank you, Mr. Chairman.

Mr. **Waxman**. Thank you very much, Mr. Leland.

Mr. Preyer?

Mr. **Preyer**. Thank you. I just want to say it is a pleasure to welcome Dr. Hines back, and you are an eloquent spokesman, as always, for your cause.

I don't think I have had a chance to hear Dean Bowie before, but you also made a most impressive presentation.

I certainly agree with Dr. Carter that Meharry and Tuskegee, and Morehouse and Xavier are national resources, and I know in this day of budget restraint, it is hard for us to do everything we would like to do, but I certainly hope that this is one area in which we will go the extra mile to try to maintain or improve on these programs.

Dean Bowie pointed out the untold hours that you put in on counseling for your special needs of students, and I am sure that your jobs are a lot tougher than the average dean's job of a university, and I thank you for what you are doing and wish you well, and thank you for being here today.

Dr. **Bowie**. Thank you very much.

Mr. **Waxman**. Thank you very much. We appreciate your being with us, and your testimony has been very helpful. We look forward to working with you on this legislation.

We will now turn to the provisions of H.R. 6802 that deal with the education of nurses.

Nurses make up the largest portion of the professional health work force in this country, and, while some would argue that this number of nurses is adequate, most observers and participants contend there is a shortage in hospitals and long-term care nursing that is growing critical. Hospitals in California have staff vacancies that average 70 percent; in Texas, the rate is 14 percent, and in New York hospitals the patient-nurse ratio is as high as 40 to 1, even on acute care wards.

Historically, the Nurse Training Act has successfully helped to supply the Nation's nursing needs. It is appropriate for the Federal Government to continue its role in aiding nurse education.

We are pleased to welcome our first panel of witnesses and hope they can constructively comment on the education and supply of nurses.

Before we hear from the panel, I would like to recognize our distinguished colleague, Congressman Richardson Preyer, for the purposes of introduction.

Mr. **Preyer**. Thank you. I particularly want to welcome all of you, but especially Dean Wilson, from Duke University. We are very proud of the job that she has done there, and that Duke is doing, in this area. I am sure your testimony will be good for the country, Dean Wilson.

Dr. **Wilson**. Thank you, Mr. Congressman.

Mr. **Preyer**. We are delighted to have you here.

Mr. **Waxman**. Our colleague, Congressman Broyhill, was here earlier, and I think will be joining us soon, and he pointed out to me that you were going to be with us today and had especially kind words to say about you and urged all of us to pay special attention to what you had to say. I don't think that is because he is from your area. I think it is because he has reviewed your testimony in advance.

I would like to call on Loretta Ford, dean, School of Nursing, University of Rochester, first.

STATEMENTS OF LORETTA FORD, ED. D., R.N., F.A.A.N., ON BEHALF OF AMERICAN NURSES' ASSOCIATION; CAROLYNE K. DAVIS, R.N., PH. D., ON BEHALF OF THE NATIONAL LEAGUE FOR NURSING; RUBY WILSON, R.N., ED. D., ON BEHALF OF AMERICAN ASSOCIATION OF COLLEGES OF NURSING; AND RUSSELL PERRY, MEMBER, BOARD OF DIRECTORS, NATIONAL STUDENT NURSES' ASSOCIATION, INC.

Dr. **Ford** . Thank you, Mr. Chairman.

We would like to comment briefly and ask that the full statement be included in the record.

Mr. **Waxman**. We will take the statement in its entirety and put it in the record. [See p. 219.] We would like to limit you to a 5-minute period to summarize your statements, and we will have an opportunity for questions and answers.

Dr. **Ford**. Thank you. To avoid repetition, I will focus on the nurse supply and trend issue.

First, we would like to thank the members of this committee for their concern for nursing education.

We are in general support of H.R. 6802, introduced by the chairman and several other members of the subcommittee.

We are discouraged by the administration's inability or unwillingness to acknowledge the changing role of the nurse in health care, while the demand for nursing services increases.

We also are disheartened with the administration's failure to recommend the kind of assistance that is needed to strengthen nursing's efforts to provide nursing services now and in the future.

The Secretary of the Department of Health, Education, and Welfare states flatly that there is an adequate supply of nurses, and that the only problem is to keep a higher proportion actively in the profession.

Shortages are not only a matter of numbers, nor are shortages just a matter of retention of nurses in the profession. The problem is far more complex.

According to our nationwide sample survey, there are some 1.4 million RNs with current licenses to practice. Of those, over 70 percent are employed in nursing. This is considered a very high proportion. It is much higher than the labor force participation rate for all work-eligible women, which is 56 percent. For those who have college degrees, the figure is 61 percent.

Of the less than 30 percent of nurses who are not employed in nursing, the survey found only 62,000 to be working in another field. More than 42,000 had children under 6 years of age. Forty-two thousand are seeking employment, and 104,000 are over 60 years of age.

While in recent years there has been a large increase in the supply of nurses, they have also been absorbed in the work force at a very high rate. HEW, itself, has again recently supported waivers in the medicare program for rural hospitals of 50 beds or less that cannot find RN's.

Over 601,000 nurses work in hospitals, an increase of nearly 16 percent since 1972. Nearly 80,000 RN's work in nursing homes and extended care facilities, a 42-percent increase over 1972 when the last previous survey of nurses was conducted. And the need for nurses prepared for care of the elderly is continuing to expand as a greater proportion of our population reaches the older years. The number of nurses working in public health and other community health agencies has nearly doubled since 1972.

The average staff nurse salary is under $13,000, and after years of experience they cannot expect increases much beyond $17,000.

Maldistribution continues to be a matter of concern to us. Incentives to schools to establish outreach programs in underserved areas have been a part of the Nurse Training Act, and studies show that a large proportion of nurse practitioners do provide health services to the poor and minority groups.

Efforts to provide more nursing care in underserved areas are hampered by deficiencies in the present reimbursement policies which do not allow reimbursement for nursing services. In our full statement we comment in detail on the administration's proposal and H.R. 6802.

We do have concerns about the institutional grant formula in H.R. 6802 and request that changes be made to reflect some of the differences in real costs of the three types of nursing education program. We are pleased with the full-time equivalent in the formula. We strongly urge the continuance of the scholarship program. Scholarship and availability of loan aid are absolutely essential in this time of intense inflation if the disadvantaged are to be able to obtain an education in nursing. We request that the authorization amount for student loans could be increased.

As I have noted, additional comments on the bills are included in our full statement. We hope that our information and recommendations will be helpful to you.

Mr. Chairman, I thank you for the opportunity to appear today, and I would be happy to answer any questions along with my colleagues.

[Testimony resumes on p. 227.]

[Dr. Ford's prepared statement follows:]

AMERICAN NURSES' ASSOCIATION

By

Loretta C. Ford, Ed.D, R.N., F.A.A.N.
Dean, School of Nursing
Director of Nursing Service
University of Rochester, N.Y.

Mr. Chairman, we would like to thank the members of this committee for their concern for nursing education. We greatly appreciated your support last year in quickly approving a new bill after the President had vetoed the measure passed overwhelmingly by Congress in 1978. And we would like to thank you for holding this hearing.

We will make a few introductory remarks and then comment on the Administration bill and on H.R. 6802. We are very discouraged by the Administration's refusal to acknowledge nursing's present and potential future role in meeting national needs for health care. There has been no real attempt to study or assess changes that have taken place in nursing practice and in the increasing demand for nursing services.

The Secretary of HEW has stated that there is an adequate supply of nurses and that the only problem is "to keep a higher proportion... actively in the profession."

The fact is that there is a very real shortage of nurses in many parts of this country. We would agree that it is not only a matter of numbers. The problem is much more complex. However, it is not just a problem of retaining nurses in the profession. According to our national survey, there are 1.4 million RNs who hold current licenses to practice. Of those, over 70 percent are employed in nursing. This is considered a very high proportion. It is much higher than the labor force participation rate for all work-eligible women which is about 56 percent. For those who are college graduates, the figure is 61 percent.

Of the less than 30 percent of nurses who are not employed in nursing, the survey found only about 62,000 to be working another field; more than 42,000 had children under six years of age; 42,000 were seeking employment and about 104,000 were over 60 years of age.

While there has been a large increase in the supply of nurses in recent years, they also are being absorbed into the work force at a high rate. HEW itself has again recently supported waivers in the Medicare program for rural hospitals of 50 beds or less that cannot find RN's.

About 601,000 nurses work in hospitals, an increase of nearly 16 percent since 1972. Nearly 80,000 RNs work in nursing homes and extended care facilities, a 42 percent increase over 1972 when the last previous survey of nurses was conducted. And the need for nurses prepared for care of the elderly is continuing to expand as a greater proportion of our population reaches the older years. The number of nurses working in public health and other community health agencies has nearly doubled since 197[illegible].

One cause of the shortages is turnover brought on in part by the very intensity of care required by today's technology, and frustrations about lack of autonomy, low salaries, and poor employment conditions. One New York hospital executive commenting on recent strikes there said "We fully understand the sentiments of the nurses and share the frustrations that forced them to these desperate measures."

The average staff nurse salary is under $13,000, and after years of experience they cannot expect increases much beyond $17,000.

Maldistribution continues to be a matter of concern to us. Incentives to schools to establish outreach programs in underserved areas have been a part of the Nurse Training Act, and studies show that a large proportion of nurse practitioners do provide health services to the poor and minority groups.

Efforts to provide more nursing care in underserved areas are hampered by lack of employment sites resulting from present reimbursement policies which do not allow reimbursement for nursing services.

There also is a need for new criteria to be developed by Health, Education, and Welfare for designating nursing shortage areas. What currently is being used are medical, not nursing criteria. Inner-city hosptial and long term care settings, for example, should be included in nursing shortage areas.

Administration Bill, H.R. 6800

The Administration proposal is totally inadequate even in dealing with areas which it cites as priority, such as improving geographic distribution and increasing the supply of primary care health professionals. There is no provision, for example, for aid to advanced nursing education despite the fact that the need for more nurses prepared as directors and supervisors of nursing service, educators, researchers and clinical specialists is well recognized.

The Administration bill would eliminate nursing loans and scholarships, an important source of support for students from low income families and for nurses hoping to achieve baccaluaureate preparation. Instead it would make nurses eligible for loans under the Health Education Assistance Loan Program (HEAL). The loan forgiveness feature of the NTA Loan Program is one of the key maldistribution efforts now in effect.

The HEAL program has not been notably effective in providing assistance to health professions students chiefly because of the high interest rate.

It would be even less effective in meeting the need of nursing students because of their relatively low income expectations and the fact that those in particular need of loans come from low income families.

H.R. 6800 would merge certain titles of the Nurse Training Act with those of the Health Professions Educational Assistance Act. Other NTA authorities would be abolished. Also the National Advisory Council on Nurse Training would be abolished and its functions assigned to the National Advisory Council on Health Professions.

Merger Opposed

We believe that the program for federal assistance to nursing schools and students should be retained as a separate entity and oppose all of these changes recommended in Administration bill. As the largest of the health professions, it is imperative that nursing assistance be funded and administered as a distinct entity. There are more than 1300 nursing education programs eligible for funds under the various sections of the Nurse Training Act, and merger with other programs is not appropriate.

Advisory Council

The proposal to eliminate the National Advisory Council on Nurse Training assumes that the Health Professions Advisory Council could take on and effectively handle review of hundreds of nursing education applications each year. The National Advisory Council on the Health Professions is burdened handling the programs which it already is authorized to review. Also it would not have an adequate number of nurse educators as members. We would be very concerned if the intent is that medicine, podiatry, dentistry and other professions should determine funding decisions for nursing education.

And if that is not the intent and the council membership to be increased or reorganized so as to handle nursing applications, then there seems little reason for the merger.

Authorizations proposed by the Administration would retain funding only for nurse practitioner programs and nursing special projects. All other assistance, including student assistance, except the loan program already mentioned, would be eliminated and even in that area, nursing students, a high percentage of whom come from relatively low income homes, would be competing with all other health professions students.

Effect on Enrollment

There appears to be a basic assumption in the Administration proposal that decrease of federal funds will not affect enrollments in schools of nursing. This is a false assumption. Admissions to nursing schools already showed a five percent drop in 1978-79 and applications to RN programs are decreasing. Figures for 1978-79 also showed a drop in graduations.

In summary, we feel that this bill fails to address the needs of nursing schools and students in any effective way and would do little to strengthen efforts to provide adequate nursing services for the country now and certainly not in the future.

H.R. 6802

We are in general support of H.R. 6802. We are pleased to see that the bill introduced by Chairman Waxman and several members of the committee would extend nursing education assistance through 1983. In recent years, the short periods of extension due to Presidential vetoes and other Administration foot-dragging techniques plus uncertainty about appropriations have caused serious problems for both schools and students. A longer period is needed to give programs a fair chance to work.

In addition, the longer time span would be appropriate in terms of the anticipated completion of the Institute of Medicine study authorized under P.L. 96-76, the Nurse Training Act amendments of 1979. That allows for a preliminary report to the committee with a final report two years later. That study has not yet gotten underway because it has not been funded by HEW, so it probably will not be completed on its original timetable.

Special Projects

We would concur with changes in the Special Projects section which would place greater emphasis on increasing educational opportunities for individuals from disadvantaged backgrounds and improving the geographical and specialty distribution of nursing personnel. We would only urge that adequate provision be made to assure the continuation of ongoing projects.

Institutional Support

We also are pleased to see that H.R. 6802 will continue institutional support. Most schools of nursing lack endowments and other sources of incomes available to other schools. Therefore institutional assistance has been invaluable to them in providing the faculty and other support needed to carry out provisions of the Nurse Training Act.

We do have concerns about the institutional grant formula proposed in Section 810. In the past, computation of the amounts of institutional assistance related to enrollment has been based on the net education expense per student per year. The net education expense consists of the actual cost of education, i.e. faculty salary, facilities, educational materials, equipment, etc., minus offsetting revenues. The revenues are monies received from third-party reimbursement such as medicare for patient care and instructional costs or tuition and also includes research monies.

In 1974, an Institute of Medicine study, Cost of Education in the Health Profession, showed a wide variation in educational costs among the three basic types of nursing education programs, baccalaureate, diploma, and associate degree, with diploma programs recording the highest cost. However, offsetting revenues in the form of cost reimbursement by third-party payers to parent hospitals left the hospital schools with considerably lower average annual net education expenditures.

For example, medicare reimburses hospitals for the costs incurred in nursing education activities. Those hospitals operating diploma schools of nursing are reimbursed for the reasonable costs incurred in the operation of the nursing school. It is estimated that in 1977, 28 percent of the costs of nursing education activities was reimbursed by Medicare. This estimate includes reimbursement to hospitals operating schools of nursing as well as hospitals without schools that provide use of their facilities for clinical training of nursing students.

A few baccaluareate programs receive small amounts of offsetting research revenues. However, this has been estimated at less than two percent, insufficient to materially alter the net education expenditures of the baccalaureate nursing programs.

In addition, it should be noted that baccalaureate program costs per student tend to be higher because of generally higher faculty/student ratios.

The proposed formula for instititutional support in H.R. 6802 would provide assistance to baccalaureate schools only for students enrolled in the last two years, while diploma and associate degree programs would receive institutional support for the full term of study of students enrolled. In addition, the formula is based on the same amount, $200 for 1981, $210 for 1982 and $220 for 1983, for all three types of programs.

We believe there is need for closer assessment of the real costs of each type of program in determining the support formula, particularly in light of great need for baccalaureate prepared nurses.

Advanced Education

As noted, advanced nurse training and nurse practitioner preparation are areas of priority need, and we are glad to see provisions for continuation of these programs in H.R. 6802. We have no objection to the provision in Section 222 providing for "special consideration" for nurse practitioner traineeships for residents of health manpower shortage areas. However, we would refer the committee to the comment earlier in this statement noting difficulties encountered in placing nurses in shortage areas because of current reimbursement policies and the need for a clarification of nursing shortage areas.

The continuation of traineeships also is important in making it possible for nurses to get advanced preparation. ANA fully supports these grants, in fact feels they are essential for those who have real potential for leadership but do not have money to fully finance their own graduate education. This includes single parents, older nurses with financial demands from families and many others.

Scholarships

We strongly urge the continuation of the scholarship program. Scholarships and the availability of loan aid are absolutely essential, particularly in this time of intense inflation, if the disadvantaged are to be able to obtain a nursing education. A report from the Congressional Budget Office, Nursing Education and Training Alternative Federal Approaches, showed that NTA scholarship go chiefly to exceptionally needy students. The CBO study report concluded that "the availability of NTA loans and scholarships may have been a major reason for minority enrollment increases in nursing schools."

We also would urge that the authorization amount for student loans be increased. Rising tuition costs, living expenses, and the impact of inflation clearly indicate the need for higher funding. Even in past years loan monies available have not been adequate to the need. For the 1978-79 school year, for example, loans went to approximately 1,189 programs with 26,180 students participating. The amount actually expended was $22,300,000 compared to the more than $84 million requested by the schools

Mr. Chairman, we thank you for the opportunity to appear here today, and we would be happy to answer any questions.

Mr. Waxman. Thank you very much. I want to commend you for your testimony. Before we have questions, we want to hear from the other witnesses on the panel.

Our next witness will be Dean Wilson, and I want to recognize for purposes of introducing her to us, Congressman Broyhill.

Mr. Broyhill. Mr. Chairman, we are just delighted to have Dr. Wilson with us. She is well known in North Carolina for her leadership capacity at the School of Nursing at Duke University. She has appeared before this committee in the past, and has always been most helpful, and we are delighted to have you here.

Dr. Wilson. Thank you, Mr. Congressman.

Mr. Chairman, I wonder if I may defer to one of my other colleagues to precede me in the presentation? I would like to defer to Dr. Davis.

Mr. Waxman. Certainly.

STATEMENT OF CAROLYNE K. DAVIS, R.N., PH. D.

Dr. Davis. I appreciate very much the opportunity to appear before the distinguished subcommittee representing the National League for Nursing, and my full text has been submitted. I will briefly highlight those comments. [See p. 230.]

First of all, we would like to commend both Chairman Waxman and the other committee members for the bill H.R. 6802. We believe that in recent years this particular subcommittee has demonstrated a great deal of sensitivity to the needs of nurse training programs, and H.R. 6802 is indeed no exception to that. We find H.R. 6802 is fairly comprehensive and represents a very rational approach to recognizing the existing crisis conditions that we find now in terms of looking at the availability of nurses to deliver nursing care.

Frankly, the root of many of our problems is attested to in part by the administration bill's failure to recognize the shortage of nursing needs nationwide.

Why this need is not recognized, we are puzzled and unable to understand. But two factors do emerge if one studies the second report to Congress on nursing. First is the overestimation of the supply of the new registered nurses or the new graduates per year. The chart here (fig. 1) indicates that the projections that were actually made according to the second report to Congress had estimated a continued growth until the year 1979, and then a gradual decline. In actuality, however, in the year 1977, there was a 4,000 difference between the actual and the projected number of graduates. This figure increased to 6,000 in 1978, and is estimated to be a 10,000 differential between the anticipated and actual graduations by 1981.

Let me put this in a different perspective. In 1978, the total new registered nurses graduating that year were under 78,000, so we had about an 8-percent error in that activity.

This is in face of the fact that we have had a very modest but somewhat declining Federal institutional support. The decline in institutional support over the last couple years may have contributed to some of the decreases in enrollment as faculty members were not rehired in anticipation of the losses in capitation in order to alleviate the anticipated fiscal problems within one institution.

The second factor that we believe was at work was that there was not a recognition of the need in terms of the demand factor, an underestimation of the demand. In the second report to the Congress it was stated that there was only supposed to be a 22-percent increase in the utilization of nurses during this period of time by—1985—because, and I quote, "of the impact of the strong cost containment programs."

There was another study reported in that same report which indicated there could be between a 48- and 104-percent increase in the utilization of registered nurses by 1985 and, in fact, significant changes have occurred in the health delivery system since 1972. We have had an increase utilization of nurses in nursing homes, home care agencies and industrial areas as well as in the acute care hospitals.

Let me illustrate by my hospital at the University of Michigan. The staffing in our various intensive care units has almost doubled in the last several years and in the burn unit and our pediatrics intensive care areas. We are not alone in this. I checked with several other hospitals, and they have reported similar circumstances because of the increase in the intensity of care that is demanded and the increase in the technological level of care.

We, like others, however, have not been without the problems of acute staffing needs. We have a 22-percent budgeted vacancy at this moment. We have closed beds; we have closed operating rooms. We have resorted to the use of overtime of our already tired and overworked nurses. We have used temporary part-time help; we have tried to increase the utilization of licensed practical nurses and aides, wherever possible, but such is not always possible, for intensive care units demand skilled monitoring by registered nurses.

Because of the increase in technology and the need for increased nurses' knowledge and skills, and the ability of the nurse to make discriminating nursing judgments, we need more nurses at the advanced level of preparation. We applaud the inclusion of the career mobility as one condition of receiving institutional funds. We also applaud the counting of the part-time registered nurse in terms of determining equivalent full-time students.

We also would suggest, however, that the concept of additional support to baccalaureate programs should be returned to the level of $400 per student equivalent because the IOM study did indicate there was a net educational cost that was higher for this program.

In summary, we would like to urge the committee to consider the continuation of the nursing scholarship programs, and in this era of fiscal constraint we believe the subcommittee should not overlook nursing's contribution to cost effectiveness and health care service. We believe the administration bill represents a short-term saving and a long-term sacrifice.

Thank you, Mr. Chairman.

[Testimony resumes on p. 255.]

[Dr. Davis' prepared statement and attachment follow:]

TESTIMONY OF

CAROLYNE K. DAVIS, R.N., Ph.D.
ASSOCIATE VICE PRESIDENT FOR ACADEMIC AFFAIRS
UNIVERSITY OF MICHIGAN

ON BEHALF OF

THE NATIONAL LEAGUE FOR NURSING

I am Carolyne K. Davis, Associate Vice President for Academic Affairs at the University of Michigan, and formerly Dean of our School of Nursing at the University of Michigan. In my current role, I am responsible for coordination of activities between our five Health Science Schools of Dentistry, Medicine, Nursing, Public Health, and Pharmacy. In addition to these units, I work with our University Hospital, a large teaching facility.

I am testifying today on behalf of the National League for Nursing, the largest American coalition of nurses and other health professionals, consumers and home care agencies dedicated to developing and improving the standards of quality nursing education, nursing services and health care delivery in the United States.

I appreciate the opportunity to appear before this distinguished Subcommittee to present our recommendations regarding the Nurse Training Act.

The basic tenent of our statement today is this: We deem it imperative that the Federal Government provide additional fiscal support to both institutions and students engaged in nursing education at appropriation levels equivalent to those in existence in 1978 (as provided for in P.L. 94-63). The alternative is to further exacerbate an already critical shortage of nurses.

The detrimental impact of the excessive reduction of federal support to nursing education, initiated by the Administrative budget requests and proposed authorization levels for FY 1979 and FY 1980, is already having a deleterious effect throughout our health care delivery system.

The nation is entering what may be the biggest nursing shortage ever. Only a few of the nation's 6,732 hospitals and 13,417 nursing homes have a full complement of registered nurses. Critical nursing shortages are being reported from all regions of our country. Some institutions, unable to find enough nurses to fill required positions, have had to close beds, or even entire units, such as, operating rooms and special intensive care areas. The shortage of nurses in many states has hit crisis proportions among hospitals, nursing homes and home health agencies. The American Hospital Association has stated that an additional 100,000 nurses are required now in order to fill current institutional needs. Empirical evidence of shortages is available from all areas of the country. Newspaper articles, advertisements and state surveys all provide evidence of the mounting crisis in nursing supply. Data available from a sample of states reporting shortages are summarized below.

California -- In its most recent survey, the California Hospital Association reported that unfilled budgeted vacancies constituted 17 percent of the State's full-time nursing staff, and that the projected number of openings state-wide exceeds 8,300. Nearly 90 percent of the hospitals responding to this survey

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indicated that an additional 1,051 RNs would be needed by 1982. Documented shortages of nurses have now surfaced in all states except Rhode Island and Delaware.

New Jersey reports over 600 RN vacancies.

Georgia -- In a November 1979 survey by the Georgia Hospital Association, approximately one out of every eight full-time budgeted RN positions is not filled. (1,800 budgeted vacancies.) Shortages of nurses are reported throughout the state, not only in the larger communities, but the smaller ones as well.

Texas -- Based upon a January, 1979 survey, estimates indicate that there are 4,129 budgeted unfilled positions for RNs in Texas hospitals. These unfilled positions represent over 12 percent of available positions for RNs. Specific statistics include:

. Positions currently budgeted and unfilled	4,129
. Additional positions for expansion of existing facilities and/or new or expanded services during the next twelve months	2,707
. Additional positions for job reclassification during the next twelve months	854
. Additional positions to replace those who will die, or otherwise leave the hospital industry during the next twelve months	1,327
. Total positions anticipated now and over the next twelve months	9,017

Maryland -- In Maryland, the shortage is escalating. Specific examples include:

.At the University of Maryland, out of 750 budgeted RN positions, 75 are unfilled.

.At Sinai Hospital (Baltimore), 43 positions out of 340 FTE are unfilled.

.At City Hospital (Baltiomre), 80 of 300 budgeted positions are unfilled.

.Prince Georges County (Baltimore), 83 of 409 positions are unfilled.

Ohio -- The Ohio Bureau of Employment Services reported that shortages of registered nurses were reported in 50 of Ohio's 88 counties.

In general, smaller community hospitals have fewer staffing problems and lower turnover than hospitals in larger cities. A notable exception is the large rural southeastern Ohio area which has a very high percentage of vacancy and turnover rates.

Pennsylvania -- The Pennsylvania State Hospital Assocation reported 1,550 budgeted vacancies.

Tennessee -- A THA 1979 survey indicated that there are 9,721 RNs employed in hospitals, representing 60 percent of the total nurses employed. Hospitals responding to the survey stated that if they were able to, and if the numbers would be available, they would like to employ an additional 1,997 RNs. If these figures are projected five years hence, the hospitals would need to employ an additional 5,232 RNs.

The heaviest shortage areas are in West Tennessee and Mideast Tennessee. The Memphis area has the next highest shortage of RNs. The Western Tennessee area's need in five years is projected to increase by 152 percent, South Middle

Tennessee 154 percent, and Mideast Tennessee 107 percent, and Memphis, 49 percent.

With regard to hospital beds that have closed due to the shortage, the City of Memphis Hospital has closed 127 beds; Jackson General Hospital in Jackson has closed 37 beds, and Rutherford Hospital in Murfreesboro has closed a wing. Vanderbilt University is functioning on a staff consisting of 2/3 temporary placement nurses. With regard to registries, temporary pools have grown. In Nashville, for example, four such pools exist with three more scheduled to begin operation shortly.

Indiana -- The Indiana Hospital Association revealed that 84 Indiana hospitals had 1,110 budgeted vacancies for full-time equivalent registered nurses. The number of RN vacancies was 55 more than reported last January, indicating a continued increase in the demand for nurses.

Mississippi reports over 1,000 RN vacancies.

Iowa -- In an April, 1979, survey by the Iowa Hospital Association, data indicated that the greatest number of unfilled positions for RNs occurs in institutions over a 200 bed size, but less than 400 beds. The least number of unfilled positions for RNs is in hospitals that have 101 - 200 beds.

Utah reports a state-wide shortage with approximately 4,000 vacancies.

Virginia -- In a 1978 survey by the Virginia Hospital Association, 15 percent of the hospitals responding indicated that beds have been closed due to a lack of staff with a range of beds closed from two to 52. Fifty-nine percent of the hospitals responding indicated that an additional 1,051 RNs would be needed by 1982, amounting to an 11 percent increase.

Louisiana reports 1,200 budgeted vacancies.

New York -- In the New York City area alone, 1,100 staff nurse vacancies are reported. One dramatic example is Bellevue Hospital where it is reported that many times one nurse has the sole responsibility for 40 patients on any evening shift.

Illinois -- In the Chicago area, 86 hospitals have reported a shortage of 1,083 RNs.

In the face of this crisis, we find it unconscionable that the present Administration is unyielding in its determination to decimate Federal financing for nursing education programs. The Administration, in its budget request for FY 1981, has proposed slashing nurse training funds from the present 1980 level of $106 million to $28.6 million. (This is even more disconcerting when considered in the light of the FY 1978 authorization levels of $206 million.) Embodied in the Administration's FY 1981 request is the total elimination of support for capitation grants, financial distress grants, construction assistance, advance nurse training grants, traineeships, scholarships, student loans, and support for nursing research.

A May 1978 CBO report to Congress entitled, "Nursing Education and Training: Alternative Federal Approaches," stated the following:

> "In fiscal year 1979, $20.5 million would be targeted to nurse practitioner programs and special projects. All other programs would be terminated. As a result, substantial decreases in the aggregate supply of RNs and a large drop in the supply of RNs with graduate training might be expected." (Underlining added)... "In addition, nursing students would be forced to assume a greater share of their educational costs by paying higher tuition charges." (p.xv.)

In recent years, Congress has demonstrated its sensitivity to the needs of nurse training programs by restoring much of the funding support which the Administration has attempted to eliminate. Apparently, as demonstrated by its FY 1981 budget request, the Administration has paid little attention to the stated concerns of Congress. This Subcommittee, however, has been consistently supportive of Federal funding in the broad areas of nurse training.

The profession of nursing is one of the oldest in this country and indeed, the world itself. While many facets of nursing have changed over the course of time, one factor remains constant: it is the nurse who serves as the primary and cohesive link which binds all of the health professions and delivery mechanisms in obtaining the ultimate goal -- the provision of quality care to the patient. This basic function is one of the pillars of strength of our health care system. It is the nurse who provides the 24-hour contact with the institutional patient - monitoring, assessing, treating, and coordination of care. It is the nurse who functions as the basic component in the delivery of health services outside of our hospitals and nursing homes, through home health agencies, community outreach programs, school nursing, public health nursing, and numerous other voluntary organizations. It is the nurse who, within all of these levels of care, is responsible for the communication and coordination between health professionals and the patient.

As the nation pays more attention to preventive medicine and diseases of the aged, there is a consensus among health planners that nurses can play an expanding role in the delivery of these services. The role of the nurse as a "patient educator" offers hope for our Nation's health status through the day-to-day repatterning of behaviors toward healthier values and activities. The nurse is the only health care provider prepared with a knowledge base broad enough to encompass the entire range of activities and behaviors related to the health of the individual.

Perhaps this role is of greatest consequence with regard to the elderly of this country. The number of persons age 65 and over increases by over 500,000 each year. Our senior citizens rely primarily on nursing services since extensive nursing care - both institutional and home based - is often the main thrust of their treatment regimens. Already our long-term care facilities report a dire need for registered nurses. The Department of Labor reports a shortage of about 150,000 nurses in nursing homes alone. Current staffing levels indicate that these elderly patients only receive an average of 12.5 minutes of nursing care per patient per twenty-four hours. Therapeutic and rehabilitative care demands more adequate staffing with nurses skilled in gerontological practice. The hardships that will afflict the graying segment of this Nation because of a misguided Federal policy reducing both the numbers of available nurses, and the quality of care that they are able to provide, cannot be ignored. The elimination of existing Federal support to nursing education would have a devastating affect on the elderly.

The increasing Federal role in the provision of primary care services, through the establishment of different diagnosis and treatment incentives; the expanding emphasis on health promotion and prevention as well as the continued expansion of HMOs, through their reliance on nursing services, suggests a further rise in the scope and importance of nursing. Moreover, the consideration of alternatives to costly institutional-based services points towards the expanded use of home health care, a concept initiated and fostered by the nursing profession a century ago.

In this era of economic uncertainty and fiscal constraint, it is often overlooked that the nurse is the most cost-effective provider of care within our health care system. Through advantageous rate differentials, and cost-saving levels of health intervention, nursing is one of the basic cost containment tools available to our country.

Research data is now available indicating that changes in nursing care can affect recovery rates, recidivism and the success of preventive health measures. By varying the organization of care, nursing studies have demonstrated a 40 - 55 percent reduction in the average length of stay of patients with abdominal surgery and renal transplants. Nurse-delivered home and ambulatory clinic care, has demonstrated success in decreasing hospital utilization. As one example, nurse clinic patients return to employment at rates that are significantly higher than physician clinic patients even when corrected for types of disease, socioeconomic background, etc.

Nurse midwives have demonstrated their ability to deliver safe high quality personalized maternity care which is also markedly less expensive than traditional hospital care. Charges for nurse midwifery services at a New York City Child Bearing Center are 37.6 percent of in-hospital care. An audit report noted that the cost to Blue Cross for families delineated at the Center is 66 percent of the cost of the plan had the same family gone to a hospital setting.

Furthermore, it should be noted that decreasing the current ratio of professional nurses to patients in direct care settings has been shown to be a costly proposition. Less educated personnel, such as nursing aides may appear to be less costly, but require so much more supervision that this practice is actually more costly, in addition to the risk that is posed to the patient's well-being. Studies show that aides average about 25% "unoccupied time" during the work day and that nurses spend 25 percent of their time supervising aides and teaching them what to do for patients.

It is difficult to imagine how an Administration so concerned with the containment of health care costs can ignore the cost-effective nature of nursing and proceed on a course which endangers the stability of the nursing profession.

The supply of and demand for nurses has been a subject of much controversy over recent years. The Administration has relied on reports that suggest that by 1985, the supply and demand for nursing personnel will be in balance. Inherent in this report were several assumptions. First, there would be no major changes in the health care delivery system and that staffing levels per inpatient would increase by only 22 percent. Second, "due to data availability, the year 1972 was critical. In the case of the requirements model, increases noted for the projection period are based upon that year." (p.77.)

This same study concluded that should there be a significant expansion of nurses' roles and responsibilities, the number of nurses required by 1985 could be as high as 1.6 million. However, the Report concluded that:

> "The overall RN requirement range projected for 1985 is between 1,205,600 and 1,716,400 based upon Vector Research. The most likely case based upon an assessment of the model assumptions compared with prevailing conditions in the health care system and current policies yield a requirement range of 1,205,600 to 1,316,300 and probably at the low end of the range. It is concluded that the aggregate national requirement and supply for 1985 will be in balance." (p. 94.) Second Report to Congress Nurse Training Act of 1975.

Other evaluations of the situation have reached substantially different conclusions. A panel of experts appointed to assist in supplying data necessary to complete these studies predicted that, within the context of expected societal changes, the demand for full-time RNs in 1982 would increase from 48 percent to 104 percent above 1976 figures. The panel included experts in the fields of nursing, health education, hospital and health administration, health research and economics.

DHEW retorted that the chances of this assumption becoming a reality, however, are very remote. Increase utilization of health services is inconsistent with the Administration's policies. "These estimates," the DHEW noted, "do not take into consideration the potential impact of strong cost containment efforts." There is indeed no simple answer to the complex problems of predicting future requirements. However, one thing is certain, significant changes in health care delivery have occurred since 1972, especially in terms of the nurse's role. In most tertiary care settings, the number of RNs per patient has increased significantly as the total patient care mix has moved closer toward intensive care due to the signficant decline in the length of stay and increasing technological complexity.

Let me illustrate this phenomenon by two examples of nurse staffing with which I am familiar. At Johns Hopkins Hospital, the nurse staffing pattern for a 14 bed Pediatric Intensive Care Unit has changed dramatically in the last several years alone. In 1976-77, this unit was staffed with one head nurse, one clinical specialist, 18 registered nurses and 10 nursing technicians. Current projections for the 1980-81 year indicate budgeted staff required as one head nurse, one clinical nurse specialist, and 36 registered nurses, with the elimination of the ten nursing technicians. This is an RN staffing increase of 100 percent for that unit alone.

At the University of Michigan University Hospital, our registered nurse staffing requirements for the Newborn Nursery Intensive Care Unit has gone from 37 budgeted positions in 1974-75 to 62.4 for the 1979-80 budget year. Likewise, our Pediatric Intensive Care Unit staffing positions for nursing have risen from 17 in 1974-75 to 45.8 in 1979-80, while our Burn Unit now calls for 46.3 budgeted nursing positions in contrast to 1974-75 when we utilized only 28 nurses. Even in our non-critical care areas our nurse staffing has increased significantly as demonstrated by the following: a single surgical unit has increased from 25 positions in 1974-75 to 38.6 in 1979-80, and a medical unit has added 11.7 nursing positions to its budgeted nursing staff since 1974-75.

Not only has the average daily occupancy rate increased in these units, but also, the intensity of care has increased significantly with more registered nurses needed to carry out such special care activities as monitoring vital functions, ventilation therapy, intravenous therapy with infusion pumps, and the handling of other special technological care.

Modern advances in treatment of patients with bone transplants, radical surgical interventions, burn therapy, neurosurgery and cardiac surgery require intensive care on a twenty-four hour basis. Many intensive care areas now require a 1:1 nurse-patient ratio in order to deliver safe and effective quality care.

While the actual number of nurses needed to meet today's requirements is the subject of great controversy, the fact remains that the supply of new graduates has now declined and the initial assumptions concerning the ability of the supply to adequately meet the 1985 needs are erroneous. Let us examine now some aspects of the debate:

The Second Report to Congress, Nurse Training Act of 1978, overestimated the number of graduates anticipated from schools of nursing from 1976-77 until 1985. (Figure one in the Appendix shows these projections graphically along with the actual graduations according to NLN data.) More accurate projections based upon actual admissions have recently been prepared by the National League for Nursing. This year for the first time in a decade, graduations from basic nursing programs declined almost two percent. However, the prediction of supply in the Second Report to Congress, while anticipating a decline, did not foresee its occurring either this early or as abruptly, and therefore, we can already conclude that the predictions on the supply side of the equation are too high. Moreover, this early error in predictions will have a compounding effect in the next few years so that by 1985, the Administration's prediction and the actual supply will, in all probabilities, be widely divergent. In 1977, the projection was too high by a factor of 4,000; by 1979, the difference was 6,000; and the differences will continue to increase by 1981 to a difference that could approach 10,000.

These signs of decline in the output of nursing education go back to 1974 when the rate of increase in admissions dropped suddenly. Aggregate admissions have not grown significantly since 1974; and in 1978, the decline in growth rate of admissions was 5.6 percent. Applications to basic programs of nursing also declined 16 percent between 1977 and 1978, the first such decline since 1960. If this current downward trend in applications and admissions is allowed to continue, and the Administration succeeds in eliminating most Federal support for nursing education, the existing shortage will grow worse.

How many nurses are currently available for practice? A September 1977 survey by the ANA indicated 1.4 million nurses held a license to practice. Of that total, 70 percent or 978,324 were in active practice. Of those in active practice, 68 percent worked full-time and 32% worked part-time. Approximately 23 percent were not employed in nursing and were not looking for nursing employment. Three percent or about 43,000 were actually seeking employment, a figure which is well within the "frictional unemployment" range. About 4 percent or 56,780 nurses were employed in other fields. Through the same survey, it was learned that about 25 percent of those not employed were pursuing further education.

The Administration has suggested that the reason for the nursing shortage is the inactive pool of licensed registered nurses. We believe it is unrealistic to expect much assistance from this group for a variety of reasons, since most of those who are inactive appear to have legitimate reasons for this status.

The presence of young children is probably the primary reason for a change to inactive status. 146,062 nurses or 34.5 percent of those nurses who are inactive have children under the age of 17. Nurses of child bearing age have a greater tendency to drop out of the work force and return later as their children mature. The 1977 survey showed a decrease in activity rates for nurses with children under the age of six and a concommitant increase for those with children ages 6 - 17. More than 1/3 of the total inactive nurse work force represent individuals over the age of 50. With increased complexities of technological nursing care it can be expected that the nurse over the age of 50 may not be able to cope with the stress and physical fatigue inherent in modern acute care nursing.

The most current discussion of the required Federal role in resolving nursing supply problems speaks solely to "numbers." However, the National League for Nursing is also concerned with the impact of insufficient Federal financial assistance on the ability of schools of nursing to achieve an optimal level of quality in the preparation of individual nursing students. This preparation includes both theoretical and clinical components, and is dependent on adequate numbers of teachers, administrators, and other supportive personnel, modern physical plants (e.g., classrooms, laboratories, and libraries), and a stable financial base that allows for needed flexibility in integrating the latest concepts in nursing education and patterns of care. The Administration's proposed elimination of what is presently 10 percent of a nursing school's annual budget will place a school in the difficult position of combating inflationary pressures and replacing a large portion of their fiscal resources.

Institutional support to schools of nursing has provided funds for recruitment of students as well as remedial programs for disadvantaged students. The cutbacks that schools have experienced in capitation have already been reflected in a decrease in remedial program activities. Talented students are now being recruited to other professional schools, such as business, engineering, and law.

There are serious categorical shortages of nurses as well, and perhaps, the most serious problem of all is the dearth of nurses in leadership positions. Presently, there is a shortage of clinical specialists, teachers, researchers, and administrators for service agencies, educational institutions, and government. During the next decade, an increase in demand for these highly specialized workers is projected. For instance, the demand for nurses with advanced training in community mental health is predicted to increase by 40% during this period. Advanced medical technology has resulted in the need for more highly skilled nurses, who are educated to provide leadership in patient care settings as diverse as infants in high risk nurseries and elderly patients in nursing homes. Clinical nurse specialists are being educated in advanced nurse training programs to assume the responsibility for developing a plan of care over a twenty-four hour period, demonstrating care to other nursing personnel, and providing health teaching and counseling to patients and families. In the near future nurses will need such skills as computer proficiency and scientific and mathematical sophistication to adjust to rapidly changing technologies in hospital settings.

Currently, over 900 budgeted faculty positions are vacant in educational programs preparing registered nurses. Between 1976 and 1978, there was a 3 percent increase in unfilled faculty positions. Among faculty teaching in all three types of programs which prepare registered nurses, only 58 percent of the faculty is prepared at the minimal or master's level, with under five percent of all faculty having doctoral preparation. Among directors of nursing services, a large proportion only have a basic diploma preparation. Only 25 precent have a baccalaureate degree and even fewer have graduate level preparation, yet these same individuals are responsible for large personnel budgets and significant policy decisions within health care agencies.

Federal funds allocated for advanced nurse training programs, currently support about 82 programs in a variety of specialists areas such as parent-child nursing, epidemiology, burn trauma, emergency care, gerontology, rehabilitation, mid-wifery, community health, oncology (cancer), critical care and primary care. These funds help schools of nursing to initiate new programs of study, extend current program capabilities and contribute to the development of new knowledge in nursing and patient care. These monies also strengthen the institution of higher education's ability to provide quality training for advanced nursing practice, teaching and administration.

To maintain the quality of direct patient care demands, more nurses require more student financial aid and better educated faculty. Other educational fields learned long ago the value of having students taught by individuals with advanced degrees, prepared to assist them in the synthesis of knowledge. This is especially true for nursing, in view of the day-to-day judgments being made by nurses that affect so many lives.

The number of graduates with advanced preparation in a clinical specialty has greatly increased in the past ten years. In 1968, 34 of all graduate students elected advanced clinical practice, while in 1977, 75 percent of all graduate nurses enrolled in clinical practice programs. Although the total enrollment of graduate students has risen dramatically in the last decade, one must also recognize that many more students are enrolled on a part-time basis. Thus, the total number of graduates from master's and doctoral programs has not increased at an adequate rate. If traineeships and fellowships for nurses seeking advanced training are curtailed, the resulting decrease in the number of graduate students will have a deleterious effect upon our health care system.

Assuming full-time study for two years, the average young person faces a cost of tuition and living expenses of $12 - $15,000, in addition to a loss of income for that period. At the same time, salaries for most nursing positions have been notoriously low. Clinical nurse specialists can anticipate an average salary of about $16,000 - $18,000 yearly. The salary expenditure curve in nursing is very flat and has a poor salary progression. At an expected salary range of $16,000 - $18,000, a young person who seeks to borrow for graduate education will find a relatively few low-cost options available, and the availability of commercial loans is generally based on one's current or future earning power.

We believe the costs of Advanced Nurse Training and traineeships present a serious dilemma which will mitigate against the future benefits of improved health care if students do not receive Federal assistance. Graduate trained nurses represent a national resource and as such ought to have high priority in Federal funding for nursing. Scholarships for exceptionally needy students would complement minority recruitment and retention activities as well as reduce financial hardships for students unable to secure adequate financial aid from other Federal student assistance programs.

In addition, the current nursing loan program, with its loan forgiveness provision, can serve to encourage nurses to practice in shortage areas. If this program is dropped, we will lose another low cost incentive to provide for better geographic distribution of nurses.

Loss of traineeship, scholarship and nursing loan funds will surely exacerbate the already significant decline in enrollments, especially at the advanced nurse training level. This will ultimately lead to a shortage of qualified faculty prepared to teach basic nursing skills, as well as a shortage of advanced clinicians and practitioners who are being prepared to deliver cost effective health care services.

The health of Americans and the health financing responsibility of the Federal Government can benefit from nursing research produced by doctorally prepared nurses. Little attention has been devoted to mobilizing the knowledge and abilities of nurses, which is the largest group of specially trained providers in developing and implementing reform from within the system. Research-based changes in nursing care may lead to savings at least as great as those produced by utilization review. In addition, research-based emphasis on home health care built on nursing services can achieve change but avoid the burdens of new regulations or legislative changes.

Sixteen universities now award doctoral degrees in nursing but these 16 are graduating fewer doctorally prepared nurses this year than five years ago, when there were only nine doctoral programs. Although enrollments in doctoral programs have continued to rise, the large number of part-time students has prolonged the completion time for this degree. Pre-doctoral National Research Service Awards currently support only 119 fellows. In many doctoral programs this is the only form of student assistance available for full-time students. Total funding for Nursing Research has been at a $6 million level for the last four years (In contrast, this year's budget for NIH is over $3 billion!). The benefits that have been demonstrated from nursing research merit expanded support, especially in those areas targeted to cost-effective clinical care.

Nursing makes a unique contribution that has been long neglected both within nursing and the Federal Government. Health is a major concern for most of the nation's taxpayers. Health care has become the third largest industry in the United States and is growing rapidly. Registered nurses constitute the largest group of health professions and yet are grossly underrepresented in most Federal and State health policy and planning councils. Now that nursing has a growing capability to contribute research data to health care policy on a national level, we urge that nurses be appointed to more national health policy-making councils.

We turn now to your distinguished Subcommittee, as we have in the past, to intervene. In recent years, this Subcommittee has demonstrated a sensitivity to the nursing profession and the needs of nurse training programs.

The evidence that an adequate supply of nurses can only be achieved by continued Federal support has shifted further in the past year toward full justification of the continuation and expansion of funds to Nurse Training programs. The Subcommittee has recognized the facts in previous years and has continued to recommend policy approaches that have the potential to alleviate the root causes of present nursing problems. We applaud the Subcommittee, and staff, for considering the Nurse Education proposal. And, Congressman Waxman is to be commended for his diligent efforts to insure that the Nurse Training and other Health Manpower authorizations are expeditiously extended by this Subcommittee.

In general, we find the proposal to be a comprehensive and rational approach to existing crisis conditions. The continuation of institutional support through baseline levels of Federal financial support to nursing schools is a critical element in resolving present problems. Without this subsistence level of basic support, many of the nursing programs in our country would face financial hardships so severe that the viability of their continued existence would be open to question.

We are especially pleased with the inclusion of a career mobility program as one of the conditions for the receipt of institutional funds. Many nurses who wish to continue their eudcation are heads of single-parent families or are middle-aged women who lack the financial resources to do so. In addition, allowing part-time equivalents to be counted in the institutions' enrollment figures will be of great assistance in alleviating the fiscal burdens that schools presently face. This change in the current law is surely an essential and justifiable one, given the fact that part-time students assume their fair share of institional expenditures.

We do have some concerns regarding the proposed decreased level of support per student enrollee from $400 to $200 in collegiate schools of nursing. We feel that this decrease will be very detrimental to institutions of higher education, particularly because the decrease occurs at a time when these institutions face financial distress due to the withdrawal of a variety of other funding sources.

We also strongly believe that the continuation of a nursing scholarship program, due to its potential to attract new nursing students from an ever-declining pool of eligible high school graduates, is essential to insure an adequate supply of nurses in the future. Therefore, we respectfully request that the

Subcommittee give serious reconsideration to the possibility of retaining this vital program. Although we are satisfied with the proposal's provision of very reasonable interest rates in the loan program, we feel that the high cost of nursing education requires additional inducements with which to attract the most qualified students. As a program which fosters the entry of individuals from disadvantaged backgrounds into the nursing profession, nursing scholarships would also be a very key program in correcting the inadequate current level of minority representation in the nursing field.

We are very pleased that the Advanced Nurse Training authority has been retained since funding for these programs is our highest priority. Graduates of these programs will alleviate the very serious shortage of nurses in leadership positions, which include administrators, clinical nurse specialists, teachers and researchers.

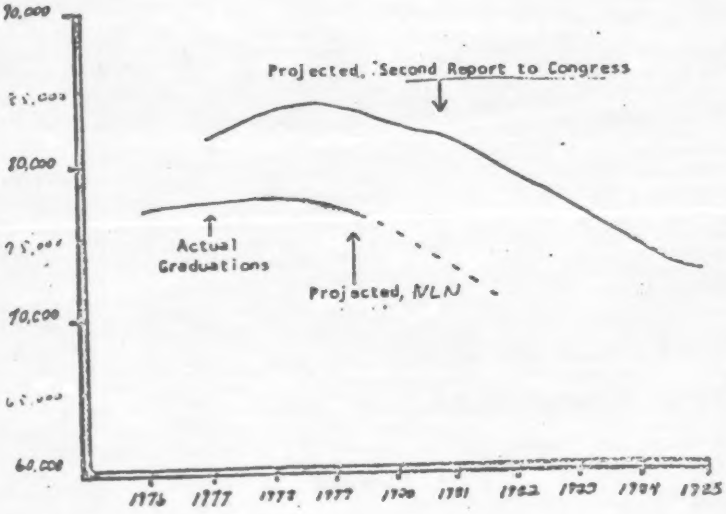
Finally, the continuation of programs of support for Nurse Practitioner Training and Special Projects preserve viable mechanisms through which the Nation's nursing supply and distribution problems can continue to be addressed.

Thank you for affording me the opportunity to appear on behalf of the National League for Nursing and the millions of patients served by our members.

APPENDIX

Figure I

Graduations from Registered Nurse Education Programs, Actual, and Projected to 1985



Source of Projections - Second Report to Congress, Nurse Training Act of 1975

Source of Actual - NLN Surveys of RN Schools of Nursing

Mr. **Waxman**. Dean Wilson?

STATEMENT OF RUBY WILSON, R.N., ED. D.

Dr. **Wilson**. Today, I am representing the American Association of Colleges of Nursing, and we wish to congratulate the committee for its fine work. As has been alluded to, it has been my privilege to work with the committee before, and it is so again.

The AACN wishes to thank the members of the subcommittee for their support of nursing education, and my remarks will highlight those sections of H.R. 6802 introduced by the chairman and several other members of the committee and will address particularly the education of nurses.

The American Association of Colleges of Nursing represents 250 nursing programs located in senior colleges and universities in the United States, both private and public. These are responsible for baccalaureate, master's, and doctoral education for nurses. This includes baccalaureate education for graduate nurses, both diploma and associate degree-prepared, as well as offering continuing education for all nurses.

In coming before the subcommittee I am pleased to report that Federal support has been a successful program. As a dean of nursing, I can speak to the cost of good clinical education. The ratio of 1 to 8 or 1 to 10 must be maintained between the nurse-teacher and students to assure patient safety and effective student education. Since nursing is taught not only in classrooms but also in hospitals, clinics or patients' homes, students must be closely supervised and guided. This is particularly problematic when remote sites are used in an effort to influence students to work in malserved areas as graduate licensed nurses. This illustration is to underline the importance of continuing institutional support for schools of nursing during the years in which students receive their clinical training.

The proposed legislation speaks to the needs to offer incentives for programs which facilitate career mobility, increase the opportunity for disadvantaged or minority students to pursue careers in nursing and make part-time study a realistic option.

The American Association of Colleges of Nursing supports these purposes and pledges to work with the Congress toward the realization of these goals.

The American Association of Colleges of Nursing recognizes that the support of the Federal Government for students of nursing has been significant. The availability of low interest loans, scholarships, and the support for advanced training has made it possible for nursing students to pursue their education. Loss or a radical change in this support would decrease the numbers of nurses available to meet the health needs of the American public and/or significantly delay their entry into practice.

Advanced nurse training programs are in desperate need of Federal support. Approximately 4 to 5 percent of the total active nurse force has completed graduate study in nursing. From this small group come nurse administrators, teachers, clinical nurse-specialists and nurse researchers. Nurses who have completed graduate preparation in nursing are truly a national resource. Augmentation of their small numbers can be regarded as a Federal responsibility conjointly with the nursing profession program, and training support, for master and doctoral education is vitally needed for continuing education. It is for this reason that we make a strong statement in support of continuing the traineeship program for advanced nurse training. Failure to provide support through traineeships will occasion a serious decrease in teachers, administrators, specialists, and researchers.

There have been public statements that Federal support, for nursing education, is no longer necessary. I disagree. The serious and already explained shortage of nurses in hospitals requires that Federal support for nurse education continue. We have no studies that demonstrate that education of nurses encourages nurses to leave practice. On the contrary, the Congress of the United States does have evidence that support for nursing education has encouraged more young people to enter nursing education programs and nursing practice.

It has been my privilege to serve on the National Council of Nurse Training, and this has provided me with a rare knowledge of needs of nursing and to verify that the provisions initiated and supported by this committee have been relevant and effective in influencing positively the preparation and practice of nurses.

I urge the members of this subcommittee to continue to support nursing education programs. Mr. Chairman, I am grateful for the opportunity to appear here today and would be pleased to answer questions with my colleagues.

Thank you.

Mr. **Waxman**. Thank you very much, Dean Wilson.

I would like to call on Russell Perry, a nursing student at Trenton State College and a member of the board of directors of the National Student Nurses' Association.

STATEMENT OF RUSSELL PERRY

Mr. **Perry**. Mr. Chairman, and members of the committee, the National Student Nurses Association is pleased to have this opportunity to present testimony in support of the Nurse Training Act Amendments of 1980. NSNA is a 35,000-member organization for undergraduate students of nursing. I am Russell Perry, a nursing student at Trenton State College in New Jersey and member of the NSNA board of directors.

NSNA clearly recognizes the spending restraints all of us, including Congress, are living with. We feel that the Nurse Training Act can provide for preparation of competent nurses who can work in underserved areas and specialty areas.

In this statement we wish to focus on Nurse Training Act assistance to undergraduate students, as well as the National Health Service Corps.

Tuition costs to students have been rising sharply in the past few years. However, tuition alone is not enough to cover the operating costs of an educational institution. Inclusion in the Nurse Training Act of an institutional support mechanism for schools meeting specific enrollment objectives or educational priorities would assist the schools as well as helping meet national health needs.

STUDENT LOANS

Loans have become the primary method for nursing students to finance their educational costs. A 1979 survey of members by NSNA showed that 52 percent surveyed received some type of Federal financial aid.

Of those receiving Federal aid, 45 percent, or almost half, were recipients of Federal nursing student loans. Eighty-four percent of the students receiving Federal aid stated that they could not continue school without that assistance.

Nursing students are in an unusual situation as far as financial aid is concerned. Most nursing education programs that prepare a student for initial licensure as an RN take place at the undergraduate level, in an associate degree, baccalaureate, or diploma program.

However, even though they are undergraduates, the cost of nursing education is higher than that of a liberal arts candidate because of clinical laboratory costs, uniforms, and higher tuition, due to increased costs to the educational institution.

In the NSNA survey cited above, 54 percent of the total respondents indicated that they paid $2,000 or more for their education per year. The survey also showed that 50 percent of the respondents came from families with incomes below $15,000 per year.

The situation of minority students is one of particular concern to NSNA. Minority enrollments are dropping. The December 1979 Health Resources News cites distribution of 1974 nurse training scholarships and loans. The distribution is far higher among minority students than their actual representation in nursing education programs, indicating proportionally greater need.

The recent creation of a separate cabinet-level Department of Education has created some speculation that undergraduate nursing students' assistance should come more under this department with other undergraduate students. This would create several problems.

Under present regulations, nursing programs participating in the nursing student loan program cannot participate in the guaranteed student loan program. As already stated, the cost of nursing education is higher than the average. Undergraduate nursing assistance should remain a priority in the Nurse Training Act. Continuity between undergraduate nursing student assistance and other provisions of the act is important, to avoid further dilution of Federal nurse training incentives.

Of course, NSNA realizes that Federal financial assistance to nursing students carries an expectation that the recipients will use their educational preparation to meet national health priorities and needs. Loan forgiveness for service in a geographically underserved area or specialty area is one method by which this can be accomplished. In the NSNA survey, 72 percent of the students receiving Federal assistance said that they would be willing to practice in an underserved areas as an option to repay a Federal loan. Nursing students are not asking for a free education at Government expense; we are asking for help to complete our nursing education and enter into active nursing practice.

SCHOLARSHIP GRANTS

There are students with exceptional financial need for whom the burden of debt resulting from large amounts of nursing student loans is prohibitive. Scholarship grants enable qualified students in financial distress to complete their education when it would otherwise be impossible. We urge the continuation of the scholarship grants.

NATIONAL HEALTH SERVICE CORPS

For the 1979-80 year, 80 NHSC scholarships were available to baccalaureate nursing students, while 620 applications were received. Obviously, nursing students wish to participate to a greater extent than scholarships are available.

The National Health Service Corps has just begun placement of health providers other than physicians in underserved areas. These providers may prove to be more cost effective, but more time is needed to realistically evaluate this.

We urge the continuation of the National Health Service Corps scholarship program. In addition, we ask that consideration be given to increasing the number of awards available to baccalaureate nursing students.

In summary, NSNA feels that continued Federal support to nursing education through the Nurse Training Act is vital. Since the emphasis has shifted from simply increasing the numbers of nurses to increasing the number of nurses prepared to practice in geographic or specialty underserved areas, the need is more acute. No one has yet found a guaranteed way to accomplish this, and nursing education programs and nursing students need financial support to explore new, more effective methods to meet the health problems of the United States in the most efficient and economic way.

[Testimony resumes on p. 268.]

[Mr. Perry's prepared statement follows:]

STATEMENT OF RUSSELL PERRY, MEMBER, BOARD OF DIRECTORS, NATIONAL STUDENT NURSES' ASSOCIATION, INC.

The National Student Nurses' Association is pleased to have this opportunity to present this statement in support of the Nurse Training Amendments of 1980. NSNA is the 35,000 member organization for undergraduate students of nursing.

Now more than ever, nursing education stands in need of federal support for its continuation and improvement. There has been a great deal of controversy recently about whether or not there is a nursing shortage. (An Institute of Medicine study is in progress on this subject). However, it cannot be denied that there is a shortage of nurses practicing in underserved areas and in certain specialty areas. The Nurse Training Act can help provide some remedies for this situation by increasing the nurses' preparation and incentives for practice in these areas.

The National Student Nurses' Association clearly recognizes the spending restraints all of us, including Congress, are living with. Current expenditure of public funds must be conservative and produce provable, cost-effective results. We feel that the Nurse Training Act can provide for preparation of competent nurses who can work in underserved areas and specialty areas, to provide more health care to the general population at lower cost than some other health professionals.

In this statement we wish to address the general areas of the Nurse Training Act, particularly assistance to students, as well as the National Health Service Corps.

Institutional Support

Tuition costs to students have been rising sharply in the past few years. However, tuition alone is not enough to cover the operating costs of an educational institution. Other sources of funds for nursing educational programs, such as private philanthropy, are decreasing as reliable alternative sources of income. Schools of nursing who wish to undertake innovative programs and enrollment activities need a source of financial support. Inclusion in the Nurse Training Act of an institutional support mechanism for schools meeting specified enrollment objectives or educational priorities would assist the schools as well as helping meet national health needs. Of particular importance is institutional support aimed at an increase in the number of B.S.N. programs available to graduates of diploma and associate degree nursing programs, an increase in the number of graduates of nursing education programs who practice in underserved areas, and an increase in representation of minority/disadvantaged groups.

Statistics indicate that admissions, enrollments, and graduations of blacks and men in basic nursing programs have decreased between 1975 and 1978. The proportion of blacks admitted in 1975 was nine and one tenth percent, in 1978, seven and two tenths percent. Enrollment and graduation fugures have declined similarly. (National League for Nursing, Data Digest, Update on Nursing Education, 1979)

Special Projects Grants

This provision has provided funds for nursing education programs to undertake projects to increase the numbers of minority students in nursing and also for innovative educational programs for both formal and for continuing education. It has encouraged creative concepts to be initiated and evaluated in nursing education. We urge its continuation.

Advanced Nurse Training

The health field is desperately in need of nurses prepared at the graduate level. Presently, approximately four percent of nurses are prepared at the master's or doctoral level. Many geographic areas simply do not have graduate nursing education programs available. These programs are the source of nurse educators, administrators and nurse clinicians, many of whom are prepared in primary as well as acute care settings. As an undergraduate student association, we strongly see the need for competent, qualified nurse faculty members to educate today's undergraduate nursing students. The need for nurses with administrative and supervisory preparation is also acute.

Nurse Practitioner Programs

This, in the past, provided for preparation of nurse practitioners with an emphasis on primary health care in geographically underserved areas. The nurse practitioner is able to practice in sites without full time physicians, thus providing a source of primary health care to underserved populations. No specific cost data is available, but education of a nurse practitioner is less expensive than that of physician preparation, although the scope of practice does differ.

ASSISTANCE TO NURSING STUDENTS

Traineeships for Advanced Nurse Training

As stated above, the need for nurses prepared at the master's and doctoral level as educators, administrators, and primary care clinicians is acute. Many nurses currently enrolled in or planning to enter these educational programs are at midcareer, when it is extremely difficult to cease full time professional employment and enter on a further educational preparation program, both financially and personally. These individuals need financial support, and are ineligible for the bulk of state and private financial aid resources.

Student Loans

For the 1978-79 school year, the nursing student loan program was used by approximately 1,189 nursing education programs with 26,180 students participating. Loans have become the primary method for nursing students to finance their educational costs. A 1979 survey of members by the National Student Nurses' Association showed that fifty-two percent surveyed received some type of federal financial aid. Of those receiving federal aid, forty-five percent, or almost half, were recipients of federal nursing student loans. Eighty-four percent of the students receiving federal aid stated that they could not continue school without that assistance.

Nursing students are in an unusual situation as far as financial aid is concerned. Most nursing education programs that prepare a student for initial licensure as an RN take place at the undergraduate level, in an associate degree, baccalureate, or diploma program. This is in contrast to the health professions whose initial preparation is at the graduate level. However, even though they are undergraduates, the cost of nursing education is higher than that of a liberal arts candidate because of clinical laboratory costs, uniforms, and higher tuition due to increased costs to the educational institution. In the NSNA survey cited above, fifty-four percent of the total respondents indicated that they paid $2000 or more for their of education per year. In fact, twenty percent were paying $3500 or more to meet the cost of their nursing education. The survey also showed that fifty percent of the respondents came from families with incomes below $15,000 per year, and fifty-four percent were working 16 hours or more per week in addition to going to school to meet tuition costs.

The situation of minority students is one of particular concern to NSNA. For many years, we carried out a minority recruitment project under Division of Nursing special project funding. However, minority enrollments are dropping. The December 1979 Health Resources News (Vol. 6, #11) cites distribution of 1974 Nurse Training scholarships and loans. Of the scholarships, twenty percent went to black students, four percent to Hispanic students, and one and three tenths percent to American Indian and Asian students. Eighteen percent of the nursing student loans went to black students. The distribution is far higher than the minority students' actual representation in nursing education programs, indicating proportionally greater need.

The recent creation of a separate cabinet-level Department of Education has created some speculation and suggestion that undergraduate nursing students' assistance should come more under this department with other undergraduate students and that nursing students should make increased use of the Guaranteed Student Loan Program. This would create several problems. Under present regulations, nursing programs participating in the Nursing Student Loan Program cannot participate in the Guaranteed Student Loan Program. As already stated, the cost of nursing education is higher than the average. Additionally, nursing students cannot be equated with a basic liberal arts student, because they will be prepared to practice nursing upon graduation and licensure, meeting a national need. If the purpose of having a Nurse Training Act is to prepare nurses who can better meet U.S. health delivery needs, undergraduate nursing assistance should remain a priority in the Nurse Training Act. Continuity between undergraduate nursing student assistance and other provisions of the Act is important, to avoid further dilution of federal Nurse Training incentives.

Of course, NSNA realizes that federal financial assistance to nursing students carries an expectation that the recipients will use their educational preparation to meet national health priorities and needs. Loan forgiveness for service in a geographically underserved area or specialty area is one method by which this can be accomplished. In the NSNA survey, seventy-two percent of the students receiving federal assistance said that they would be willing to practice in an underserved area as an option to repay a federal loan. Preferential availability of loan money to students planning to practice in primary care areas, continue on for graduate education in nursing, or other specified national priorities is another option. Nursing students are not asking for a free education at government expense, we are asking for help to complete our nursing education and enter into active nursing practice.

Scholarship Grants

Most nursing students realize that student loans are the main mechanism they can expect to use to finance their education. However, there are students with exceptional financial need for whom the burden of debt resulting from large amounts of nursing student loans is prohibitive. Scholarship grants enable qualified students in financial distress to complete their education when it would otherwise be impossible. We urge the continuation of the scholarship grants.

National Health Service Corps

Only recently have National Health Service Corps scholarships been made available to baccalaureate nursing students. For the 1979-80 year, eighty NHSC scholarships were available to baccalaureate nursing students, while 620 applications were received. (Health Resources News, Vol. 6, No. 8, Sept. 1979) Obviously, nursing students wish to participate to a greater extent than scholarships are available.

The National Health Service Corps has just begun placement of health providers other than physicians in underserved areas. These providers may prove to be more cost effective, but more time is needed to realistically evaluate this. Sufficient time has not elapsed to determine whether the health professionals, especially nurses, will stay in these underserved areas once their service period has expired.

We urge the continuation of the National Health Service Corps scholarship program. In addition, we ask that consideration be given to increasing the number of awards available to baccalaureate nursing students.

Summary

The National Student Nurses' Association feels that continued federal support to nursing education through the

Nurse Training Act is vital. Since the emphasis has shifted from simply increasing the numbers of nurses to increasing the number of nurses prepared to practice in geographic or specialty underserved areas, the need is more acute. No one has yet found a guaranteed way to accomplish this, and nursing education programs and nursing students need financial support to explore new, more effective methods to meet the health problems of the U.S. in the most efficient and economic way. Nurses and nursing students recognize their obligation to society as members of the health delivery system. Our goals cannot be achieved, however, without some agreement on priorities and systematic support.

Mr. **WAXMAN**. Thank you for your testimony. Much has been said about the high turnover rate in nursing. While figures are in dispute, everyone seems to agree more nurses leave the field each year than enter. What would you suggest the Federal Government do, if anything, to improve the retention?

Dr. **FORD**. There are several reasons for this. One of them, of course, is the problem of shortages. There are not enough staff to accommodate the needs of patients. The nurses are very pushed, both psychologically and physically, to accommodate the shortage. Another important consideration, is the type and kind of people that are available. Certainly the acute level of the patients today, and the expanded of medical technology, require better and more qualified nurses to care for patients in ambulatory services, tertiary care centers and secondary care centers as well as long-term care.

The whole profile of any one staff impacts greatly on the retention of nurses. Nurses are often required to do everything else but take care of patients. Frequently nurses are supervising people who are not qualified to do the kind of care that is needed by patients today.

Mr. **WAXMAN**. Many hospital administrators have commented that the clinical and real-world experience of recent graduates is insufficient in staff work. What efforts are you making perhaps with institutional support moneys for special projects, to improve the clinical education of nurses?

Dr. **WILSON**. Having been in nursing practice and education for some time, the intervention and support systems necessary for the delivery of patient care have been explosive, and that even though we really have not extended the length of the educational programs, we are being asked to put more and more into the same period of time.

I know a number of educational institutions have been expanding the length of clinical time that is available for students-learing. At Duke University several years ago, we instituted during the summer, between the junior and senior years, a professional nurse assistant program that essentially provides the students with a clinical preceptorship for 2 or 3 months. Thus, they are having some additional nursing practice under supervision, but also during the time they are also nursing students.

I think that as we really have more demand placed on us, as has already been cited by Dr. Ford, of looking at the complexity of care, it means that there is more and more of a burden that is placed on the educational programs to prepare students.

I think, too, we have to remember in the baccalaureate programs, as well as in the diploma and associate degree, that these students are being prepared initially for practice. There are really so many and varied settings and opportunities for practice that it is nigh to impossible to prepare every graduating senior student for being able to practice immediately and with competence in any practice situation.

I do know that within some of the larger hospitals, especially the major medical centers, there is more cooperation between the schools of nursing and the nursing service departments for provision of staff orientation, intracollaboration of nurses for clinical expenses, and acceptance of graduate nurses' desires to prepare to move into a specialty area. Initial and continued education as well as progressive opportunities for the learning and practice of technical skills are increasingly being impared so nurses really can be more competent and safe in the practice of care.

Dr. Ford. Mr. Chairman, may I add to that? At the University of Rochester we have an unusual model of combining practice education and research in the unification model. I know of only one other in the country. What we could use are special project grants to allow us to put on demonstration projects, such as unification or other models of collaboration and integration of nursing practice, education and research.

Mr. Waxman. Dr. Davis, let me address this question to you. Baccalaureate schools are more expensive to run than either of the other types of programs. If there is a critical nursing shortage in this country, and I believe there is, why should we turn to the most expensive source?

Dr. Davis. I think one has to think in terms of the demand out there, in terms of patient services. We believe that we do need an additional supply of baccalaureate trained nurses because of the complexity of care, as I mentioned before, in particular, is increasing tremendously. Not only in the acute care settings, but in the home health care agencies, and in the long-term health care agencies I believe the baccalaureate programs are the only ones that currently prepare nurses for home health or community service-type activities.

Dr. Wilson. If I may add to that, I think, too, that as you really speak with individuals who are primarily responsible for nursing services, and as they do have experience with graduates from the associate, the diploma, and the baccalaureate programs, they attest it is true as far as some of the technical skills are concerned that the graduates most immediately from the associate, and I would say more particularly the diploma program, may feel they have more experience in procedural skills.

However, within a 6-month period, they are always commenting that the graduates are being faced with complex situations that do involve decision-making, problem-solving, judgment, and very much involved in the unpredictable kinds of situations. I do believe that everybody in this room probably knows that, whether or not we have been patients or have been visitors of patients, especially in a hospital, that it really is the nurse who really provides the 24-hour constant care of the patient, much more than it is the physician, if you really look at the number of minutes that a physician really spends with the patients.

So it means that within health care delivery, it is becoming paramount and more and more important, for us to be accountable for really providing safe nursing care for individuals through nurses who can utilize problem-solving techniques for safeguards.

Mr. **Waxman**. Dr. Carter?

Mr. **Carter**. Thank you, Mr. Chairman.

I appreciate what you said. It is true that you provide constant care, but on an 8-hour shift usually, with a doctor on call all the time, isn't that correct?

Dr. **Ford**. Nurses in primary nursing are also on call, sharing the responsibility with you, sir.

Mr. **Carter**. As you know, I have always supported your legislation. I think your profession is underpaid and I always have thought that. I certainly intend to continue supporting nurse training legislation.

I notice that the administration would drop Federal funding for student loans, under the Nurse Training Act, and instead expect them to borrow under the HEAL programs. But under the current HEAL program, nurses would have to borrow money with 12 percent interest.

Have many of them taken advantage of this?

Dr. **Wilson**. It depends on the situation. It depends on how severe that is. I will say that within our own student population, we will find those students going out and working. As recently as 2 weeks ago I had a student come in to see me on the advice of her instructor, because she wasn't doing as well as she should within her learning experiences. I found out the student was working 30 hours a week and carrying a full-time academic load. Within those 30 hours she was working at three different jobs. And her reason was that she did have brothers and sisters also in college, that her parents could not help but a certain amount toward her educational experiences, and she did not feel she could take on a very high loan at that kind of a percentage when she was also aware of what her salary was going to be when she completed her program.

Mr. **Carter**. I believe under the HEAL program nurses could borrow money at 12 percent, is that correct?

Dr. **Wilson**. That is a high percentage.

Mr. **Carter**. It is already a high percentage, yet under the program proposed by the administration, there really would be no ceiling on the interest rate that could be charged, is that correct?

Dr. **Wilson**. That is my understanding from our financial aid officer.

Mr. **Carter**. That is correct, I believe. So the interest rates then would go up for the going market rate. What does it cost a nurse to go to school per year?

Dr. **Wilson**. This varies as to whether or not the student is in a public or private institution. As you know, I come from a private institution, where tuition is high, but it is not the highest of current tuitions. Tuition is increasing, even at public institutions. And as far as tuition costs are concerned, they probably vary the most.

It means it costs almost everybody the same amount to live as far as room, board, books, and that kind of thing. I can say our financial aid package, and by that I mean that we have put together what we believe a student would need for two semesters, to complete two semesters at Duke University School of Nursing, next year will be close to $10,000. The tuition will be almost $5,000 for two semesters. Even with that, we have a differential tuition for the student in the junior and senior years when they are in the clinical years, and there is a higher faculty/student ratio.

Mr. **Carter**. Let me understand you. Did you say it costs about $10,000 a year?

Dr. **Wilson**. Yes.

Mr. **Carter**. If the nursing student borrowed $10,000 each year at 12 percent, the interest on the loan would be $1,200 per year, which would compound and accumulate until after the nurse had got her degree and had other training, if she chose to have that. The total amount owed would be considerable.

Dr. **Wilson**. Yes, and, of course, those costs would increase each one of those years that she is in school, and in a baccalaureate program that would be 4 years.

Mr. **Carter**. Do you favor the administration's proposal to remove the 12-percent ceiling on loans under the HEAL program and then have nursing students borrow under this program at the market rate? I expect the interest rate would be no less than 17½ percent? Do you favor this approach for your students?

Dr. **Wilson**. I think the lowest rate that would be possible certainly would be the preferred one under whatever would be the loan program. I think that we have to recognize a fact that has not been mentioned in our discussion thus far, and that is that within the last 10 years we have had a very definite change as far as looking at career goals and lifestyles of women. We have had a number of societal changes that have influenced that, and within the last several years we are very much aware of affirmative action programs that are necessary in order to obtain funds, and women are being received and admitted into schools of medicine, law, business administration, and engineering. It means that where women have primarily moved ahead in careers in nursing and education, there really is now an attraction from nursing into those professions.

It also means those individuals look at what might be their earning power upon completion of those educational programs, and, as has been cited, it is much higher within each and every one of those than nursing, even if a nurse continues and obtains graduate degrees.

Dr. **Davis**. I think one of the advantages we would see that is represented by the Waxman bill is the fact there is a loan forgiveness in that bill, which will obviously assist in promoting nurses moving into the needed shortage areas. I am afraid the HEAL program would probably promote the opposite effect. I think the nurses would obviously, because of the high interest payments, feel they would be compelled to find jobs at the highest possible earning power.

Mr. **Carter**. How would you like to start over and have to pay the money it took for you to attend nursing school at an interest rate of 17½ percent?

Dr. **Davis**. I am afraid I wouldn't be a nurse. I did not have a family situation that could have understood and accepted that kind of debt. I think that is true of many young women who come from middle- and lower-income families. The prospects of having that type of a loan to pay off is simply not feasible for most nurses.

Mr. **Carter**. Although we have a shortage of nurses at the present time, this type of loan program would have a depressing effect on applications and enrollments. I believe it would further diminish the numbers that enter our nursing schools.

Dr. **Wilson**. It would not only influence the numbers, but again, as we are looking at the profile and the composition of that nursing student body, it means, as we heard earlier this morning in testimony, as far as the disadvantaged students and the minorities, it would really be prohibitive for those individuals.

Mr. **Carter**. It seems to me it would be almost prohibitive for anyone.

What is the current percent of nursing students attending training programs on a part-time basis?

Dr. **Wilson**. I will say that has a very direct relationship to rules and regulations regarding available financial aid. And I cannot speak for all institutions, but I know that in a number that students must be full-time students in order to qualify for financial aid.

This has been brought to many people's attention by students who would like to be able to work part time, go to school part time and still be able to have some financial aid on a part-time basis.

Dr. **Davis**. I believe, too, that the national figure is something like 40 to 45 percent, because a great number of students that are enrolled in some of the associate degrees and some of the RN baccalaureate programs, are going part time. In addition, at the graduate level approximately 50 percent of the students are now part time. That has been a significant increase in the last several years, sir.

Mr. **Carter**. Fifty-two percent of nursing students now receive some Federal aid. Is that correct?

Mr. **Perry**. That is right. That is from the National Student Nurses Association survey.

Mr. **Carter**. Since we know that one-third of the nurses are not actively practicing, do you think requiring enrollment increases as a condition of Federal support is an efficient way to go about solving the nursing shortage?

Dr. **Davis**. I have no problem with that, sir, because I believe that although some of the women do step out from their career in nursing to raise families, I would submit that perhaps we are looking at a national resource in terms of health education and prevention that we have not thought about before. We are willing to put millions of dollars into health education and prevention services, and I would submit that nurses who are married and raising families may well offer that type of service already. I see them as a good national resource, because of their expertise in health.

Mr. CARTER. How do you explain the decline in the number of graduates from basic nurse training programs?

Dr. WILSON. I think I spoke a bit to that earlier, when I indicated that we are having other career opportunities available for women. I do believe that they are drawing women who ordinarily may have pursued careers in nursing.

Mr. CARTER. You have a rather distinguished alumnus from Duke, a member of the faculty there, Juanita Kreps, who entered a different profession. You might be referring to something like that.

What are the long-term trends in nursing education, especially in regard to the future viability of diploma schools?

Dr. WILSON. May I make another comment on your earlier question? I think that you made a statement earlier as to the salaries of nurses. I think that really is a very vital factor as far as individuals perhaps being more attracted, to other careers. Even though we are very interested, and we recruit heavily as far as men into nursing, there again the salary issue is very much a critical one. And in addition, I do know that there have been some articles in the U.S. News & World Report, and in some of the other media, including the newspapers, speaking to the environment in which nurses are working. Nurses really are wanting to be able to be more of an advocate for patients for improved quality care, and at times they really do find themselves in settings where they are limited as far as the influence that they can wield or how much a certain organizational system is willing to accept. I believe nurses are going to be more assertive to really support their principles, their education, what they believe the quality and kind of nursing should be, and that if that really cannot be obtained, yes, they may indeed decide to seek employment elsewhere.

Dr. DAVIS. May I add one thing? I believe that the significant drop in our student support programs has perhaps also been a factor in the decline in the enrollments in the various programs.

Mr. PERRY. Can I add a comment, also?

Mr. WAXMAN. We will have other members of the committee that will want to ask questions. I know Dr. Carter had a question pending.

Mr. CARTER. No, that is all.

Mr. WAXMAN. I want to thank you for your answers, but I want to call this time to a close so we can recognize other members for their questions, and so we can hear other witnesses.

Mr. Leland?

Mr. LELAND. Thank you, Mr. Chairman.

If all of the nurses or nurse graduates in Texas were to graduate and stay in Texas, I understand that even if they all went to work, that only one-third of the need of nurses in Texas would be fulfilled.

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How common is that among other States? Do you have any idea at all?

Dr. DAVIS. The longer testimony that we are submitting speaks to that in great detail with data from a significant number of States. In addition, we will submit an abstract of newspaper clippings from 43 States that we shared with a Senate committee last week. This is very recent material. It does indicate serious staffing shortages and indeed also indicates there has been concern in some hospitals in terms of their accreditation process, which may be in jeopardy because of the significant shortages. [See p. 278.]

Mr. LELAND. I also am concerned, and I hope this is not an embarrassing question, but Dr. Wilson somewhat alluded to it earlier, about the political implications about why nurses don't want to practice after they have practiced for several years; they sometimes get disillusioned because of the lack of ability to be recognized as leaders in the health care profession because of the imposition of primarily doctors, with all due respect to my great colleague and friend, Dr. Carter.

For whatever reason, doctors tend not to want the nurses to assume that leadership position. In Texas, in particular, I know, having served in the State legislature for 6 years. The Texas Medical Association has made life pretty miserable for the majority of nurses and particularly nursing students who have wanted to be progressive and wanted to step out as nurse practitioners, and get out and head up the field and work in parallel with the medical profession.

Can you just comment on those implications, if you will?

Dr. FORD. Yes, sir. I have long years of experience with that——

Mr. LELAND. If you feel brave enough.

Dr. FORD [continuing]. In terms of developing the nurse practitioners and the recognition of the contribution that nurses can make to the unmet health needs in populations that are now not well served in health services.

One thing that is needed is reimbursement for those nursing services so that indeed they are recognized as professionals. Nurses have a service to offer, and it can be delivered in conjunctive ways or independent ways with physicians and other colleagues on the health care team, but the recognition of the nurse, as a true professional who has a service to deliver through reimbursement, is one aspect.

Many changes have been made to allow nurses to function in such a way within the scope of nursing to deliver high quality care, particularly in relation and promotion of health. Also there is a need for the preparation of leaders in nursing—teachers, administrators, who provide the type and kind of leadership in the delivery of care that would allow these nurses to function more expansively in a variety of settings.

Dr. WILSON. I would like to comment that I believe there indeed not only should be, but we really do have to put forth more concerted effort, on both the part of the nursing and the medical professions as far as increased collaboration in working together, because the ultimate goal is the same for both of us, and that is quality care for the patient.

However, physician dominance has been very much a tradition, and one that really gets very hard to break, and yet I know from even my own experience that when you really are a qualified individual, you can develop a colleague relationship with physicians. But I would also say, as we are speaking to the preparation of nurses, it does not mean that all nurses have as much a similar kind of preparation as the physicians do. This makes it difficult at times as far as even we are concerned within nursing, because we really do have more levels of preparation, and it is much easier to establish a colleagueship with someone who is a peer.

Mr. LELAND. You are tough ladies. I am a pharmacist, and we have the same problem, by the way, with doctors, Dr. Carter.

Mr. CARTER. Will the distinguished gentleman yield on that?

Mr. LELAND. I will be happy to yield to to my amigo.

Mr. CARTER. Thank you. I resent the implications of my good friend from Texas. I have served on this committee for quite a few years, and never once have I in any way offended any nurse who appeared before this committee. I have supported your profession, all the way. I have a friend over here who has served with me most of the time I have been here, and he will state the same thing. While I am an M.D., a physician, and I am thankful that I am, if you go back to the hospital where I came from, I think you will find that the nurses there won't say that I was arbitrary or anything like that.

Certainly I want you to have your place in the Sun. I think you deserve it, and I have supported it for 16 years, and I will continue to do it, just as I have supported pharmacy, and assistance to nurses and pharmacists. Show me once where I have departed from my support for these professions.

And I thank the distinguished gentleman for his cutting remarks.

Mr. LELAND. Mr.—Dr. Carter——

Mr. CARTER. Yes.

Mr. LELAND [continuing]. Let me say if all doctors, particularly those in Texas who my limited experience has given me an opportunity to learn a possible crude view about the medical profession—if all the doctors I worked with in the past were like you, I think pharmacy and nursing would be much, much better off. My remarks did not have any reflection on my friend, Dr. Carter, from Kentucky, at all. I was talking more specifically about the Texas Medical Association and the doctors in Houston, and those who have fought to keep nursing and pharmacy and other medical professions behind the professional veil because of the mystic that was created by the medical profession for one reason or another.

I wish, by the way, that more of the doctors in Texas and those who run the Texas Medical Association could be more closely associated with you, as I am, so they could learn how exactly doctors ought to act. I think you are a model doctor, and I yield the balance of my time.

Mr. CARTER. Thank you, my friend.

Mr. WAXMAN. Now, to defend my profession, I would like to recognize my colleague, Congressman Preyer.

Mr. PREYER. Thank you, Mr. Chairman.

I do want to thank all of you for your testimony.

It has been baffling to me how we continue to hear the idea that there is not a shortage of nurses or that all we need to do is to retain a higher proportion of nurses. That is like saying if a bullfrog had wings, it could fly. If we could change all the conditions which keep us from retaining more people, great, but to just say because of that we don't need to develop any more nurses is very puzzling. I hope we will end the argument that there is not a shortage of nurses once and for all.

I was at Cone Hospital, which Dean Wilson is familiar with, a few weeks ago, and the administrator and the heads of all the departments, before we could talk about anything else, they would plead with me to get more nurses. That is the thing that is limiting their expansion of their services, and I take it that is probably not unique to that hospital; that you would find that at Duke, also.

Dr. WILSON. Also, at Duke, as you are aware, we are about to move into a new hospital complex, and even though we are only adding about 100 additional beds, it means that the complexity of the care has increased so much that currently, we are sitting with 200 nurse vacancies.

Dr. DAVIS. It is a fact that many others besides nursing are worrying about this. I belong to a group called the Association of Academic Health Centers, where the vice presidents for health sciences meet a couple times a year. In the last year, it seems to me the main subject of conversation has been the whole issue of nurse staffing and recruitment, how each of us are handling that particular issue.

Mr. PREYER. On that issue of the declining enrollment, which I think we see in dental schools, even in medical schools, although there are still far more applicants than places, and one of the reasons I think in the nursing field—salary is certainly an important one—but a wider reason that seems to be affecting our society generally is the fact that people who go into health care tend to be people who would study the hard sciences, chemistry, biology, physics, and all of the universities now apparently are finding that there are plenty of jobs out there in the private economy for graduates in those fields.

I understand the figures are, there are five jobs for every one applicant in the hard sciences for graduates of colleges and universities.

There is one job for every five applicants; just the reverse in everything other than the hard sciences out in the economy. So when you have that kind of market situation operating, the people who would normally be going to dental school and medical school and nurse training are far apt to be drawn off to the higher paying jobs.

I guess that is something which will just right itself over a period of time when we oversupply those fields.

The trouble is, as Lord Keynes said, in the long run we will all be dead, so I hope we can correct something beforehand.

One figure Dean Ford gave, which I would like to ask her to expand on a little as to the significance of it, when you showed your charts—incidentally, I hope those charts can be put in some form that we can use in the record, which is helpful for people like me who don't read so well, so they can study the charts. [See p. 284.]

You mentioned that there were 104,000 nurses over 60 years of age. I am beginning to reach the point where I wouldn't denigrate the abilities of anybody over 60 years of age, but what is the significance of that in terms of nursing? Is that an unusually large proportion, which means we are going to be running out of nurses, or what is the significance of it?

Dr. **Ford**. All we know is that these are people who hold an active license. Even though they hold an active license, we don't know whether they are actively practicing, so that looking at the distribution of ages is very important in terms of the availability of supply. There are certain settings where the older nurse can function well, however, as a nurse on one of our units said to me the other day—she is retiring at 62—"you won't find many 62-year-olds doing staff nursing in a tertiary care center where the physical and psychological demands are so great one can't maintain the level of energy required for that.

The expectation and hope is that nurses would remain in the work force as long as they individually choose to do so, regardless of their age, and then if necessary find the type and kind of setting which would match both their levels of energy and interest.

Dr. **Davis**. I would like to point out, too, that the great number of those nurses that are about that age level probably were educated in the Cadet Nurses Corps, which was a Federal program, the initial one, and that group is now reaching the retirement age. That may be why there was such a large group.

Dr. **Wilson**. It was during that time we took in two and three classes a year and the educational process was speeded up to meet the national defense demand.

Mr. **Preyer**. Thank you. I appreciate your testimony, and I see there is another distinguished Duke alumnus waiting in the wings here, Mr. McMahon. This seems to be Duke day here.

Dr. **Wilson**. I would mention you have another individual who is going to appear who is a Duke alumna, Sally Austin Tom, from the school of nursing, who will be representing midwifery in a few minutes. Duke day was not planned.

Mr. **Waxman**. Those of us who did not go to Duke continue to be impressed by its caliber of graduates. Thank you.

[Testimony resumes on p. 287.]

[The following information was received for the record:]

NURSING IN THE MASS MEDIA RESEARCH PROJECT
609 East Liberty Street
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THE UNIVERSITY OF MICHIGAN

EVIDENCE SUBSTANTIATING THE ESCALATING SHORTAGE OF REGISTERED NURSES AS REPORTED BY THE NATION'S PRESS, SEPTEMBER, 1979-FEBRUARY, 1980

Dramatic documentation for a shortage of nurses in the United States can be found in a review of recent newspaper articles on the subject. Headlines offering generous bounties leading to the hiring of a qualified nurse are common. (Indianapolis Star, 14 October 1979; Carson City, Nevada Appeal; 18 October 1979; Austin, Texas, Citizen, 15 October 1979.) Small town weeklies and big city dailies have devoted an increasing amount of attention to the nursing manpower shortage that threatens health care in their communities. Approximately 1,200 articles on the nurse shortage appeared in U.S. newspapers in the six month period between September, 1979 and February, 1980. Newspaper articles on the nursing shortage have increased by nearly 300% compared to the number of articles found in the same time period one year ago. The evidence of a national shortage of nurses emerged spontaneously in communities all over the country; these articles offer a rather different picture of the issue than that being given by the Carter administration. Administration statisticians and officials have concluded that there is no nursing shortage and that there will be an ample supply in the forseeable future. Based upon its unfounded conclusions, the administration has determined to reduce nurse training funds by 75% in the coming year.

According to the articles reviewed, the geography of the nurse shortage has changed markedly in a short time. Last year, the states of California, Texas, and Florida -- areas of great population growth -- reported the existence of a crisis in nursing manpower. The crisis in these states has only escalated in the past year. This year, major cities in the midwest and along the eastern seaboard, not long ago a source of surplus nurses, are now experiencing critical shortages of nurses. Indiana, Illinois, Utah, Maryland. Massachusetts, Minnesota, Missouri, Michigan, Wisconsin, Ohio, and Pennsylvania have recognized the nursing shortage as a matter of both state-wide and national proportions. Especially hard hit have been certain large cities: Chicago, Minneapolis, Detroit, Baltimore, and Philadelphia. In Chicago alone, there are an estimated 2,000 budgeted nursing positions that cannot be filled. On a national basis, there are 100,000 vacant nursing jobs.

A widely circulated review of the nursing shortage written by Patricia McCormack of UPI prompted many local newspapers to review their own nursing manpower situation. All reported concurrence with the UPI assertion that "The nation may be in the biggest nursing shortage ever." (San Jose, California, San Jose Mercury, 1 October 1979; Winston-Salem, N.C., Journal, 30 September 1979; Fort Wayne, Indiana, The Journal-Gazette, 30 October 1979; Rochester, N.Y., The Democrat and Chronicle, 23 September 1979.) The nursing shortage affects big metropolitan areas, rural areas, public hospitals and private ones, the East, the West, the South and the North. Finding qualified nurses is no longer the problem only of poor or isolated regions, but has become the headache and worry of hospital administrators and physicians all over the country. Nurse recruitment has become a permanent administrative problem for hospitals and nursing homes, and professional nurse recruiters have been hired to ease the problem.

Almost every newspaper article on the nursing shortage offered a variety of explanations for the disturbing news that there are not enough nurses to provide the kind of care expected in modern hospitals. Nurses most often cite the lack of adequate financial compensation and the unfavorable working conditions imposed upon hospital nurses. Denver nurses found that the apprentice checkers at their local supermarkets were earning more money per hour than experienced registered nurses. (Rocky Mountain News, 27 September 1979.) One nurse noted, "If I, a college-educated nurse, get $6 or $7 an hour, and the guy who puts on the hubcaps in a factory gets nearly double -- well -- it's a crime." (Chicago Tribune, 14 October 1979.) Perhaps even more troubling to nurses than money are the conditions of working in a hospital, especially if the hospital is already understaffed. In addition to the undesirable aspects of hospital work, such as weekend work and a grueling rotation schedule, nurses point out that there is no incentive to remain a working nurse. There is no place for a talented and ambitious nurse to go in a hospital, if she wants to remain in patient care. If a nurse wants to advance in her profession and to earn more money, she must quit patient care in favor of administration or teaching.

Finally, in a growing number of understaffed hospitals, even more nurses quit when they can no longer tolerate working 12- and 16- hour shifts and knowing that their patients are not receiving good care. All of these issues contribute to the huge turnover problem in nursing: California reports a 30-50% turnover in nursing positions every year, which costs, in terms of recruitment and training, $187 million dollars a year.

Certain irreversible social and technological changes have also contributed to the nursing shortage. The women's movement has opened the door to traditionally male careers such as medicine and the law. The "new breed of nurse" with a college education and a new degree of self-confidence will not accept perceived deplorable conditions imposed by hospital regimens. New opportunities for nurses outside the hospital have drawn many nurses into independent or expanded roles. Advances in surgical techniques and medical technology have created a huge demand for nurses with special training: coronary care units, renal dialysis units, and burn centers require intensive and experienced nursing if the patients are to benefit from the medical advances.

Yet if everyone has an explanation for the nursing shortage, almost no one has offered a solution for the problem. The only consistent answers have been costly, short-term "Band-aid" remedies that attempt to stave off crisis for a few more months. Flashy recruitment campaigns are common procedures. Some estimates suggest that it costs between $7,000 and $8,000 to recruit a nurse; and hospital administrators consider the money well-spent if the nurse stays for only two years. In addition to bounties ranging from $100 to $1,000 per recruited nurse, hospitals pay for national and local advertisements, trips to recruit nurses from other areas, and they offer to find and subsidize housing for nurses who accept jobs in distant cities. None of these efforts have been too successful. It is reported that Filipino nurses brought to the U.S. at great expense, especially in California and Florida, do not remain for long and experience serious cultural and language problems during their short tenures.

Temporary nurses fill up to 20% of nursing positions in some hospitals.

Concurrently, temporary nursing employment agencies reap a hefty profit from providing nurses to beleaguered hospitals at a very high rate. Staff nurses at hospitals, not surprisingly, resent the presence of these temporary nurses who earn considerably more per hour than they do and yet assume none of the major burdens of patient care such as the paperwork. Furthermore, there is no way that temporary nurses can be trained in hospital emergency procedures -- leaving open the possibility of serious deficiencies in safety standards. (Los Angeles Times, 2 December 1979.)

The high monetary cost of the nursing shortage is paid for by patients. But patients also pay another cost, potentially higher, in the quality of care they receive. Administrators insist that despite the 10-20% nursing vacancies in their hospitals, patient care is not jeopardized. Nurses and physicians tell another story. At best, an understaffed nursing service means that the nurse has no time for the other essentials such as offering emotional support and education for her patients. At worst, the nursing shortage means that patients go without needed supervision, which occasionally leads to unnecessary complications. One Florida physician summed up the situation in his hospital, "We are not providing what we say we are -- quality care." (Daytona, News, 15 January 1980.) Closing down beds and limiting admission has meant that doctors often must postpone admitting patients in need of care or surgery. (Yucca Valley, California, Hi-Desert Star, 30 January 1980, Portland, Oregon Journal, 7 February 1980, Waukegon, Ill, News-Sun, 7 September 1979.) A Minneapolis nurse recounted her nightmares coming true when she found herself making mistakes in patient care because of the number and severity of patients in her charge. (Minneapolis Tribune, 3 December 1979.)

The prognosis for nursing manpower is not optimistic. Despite the

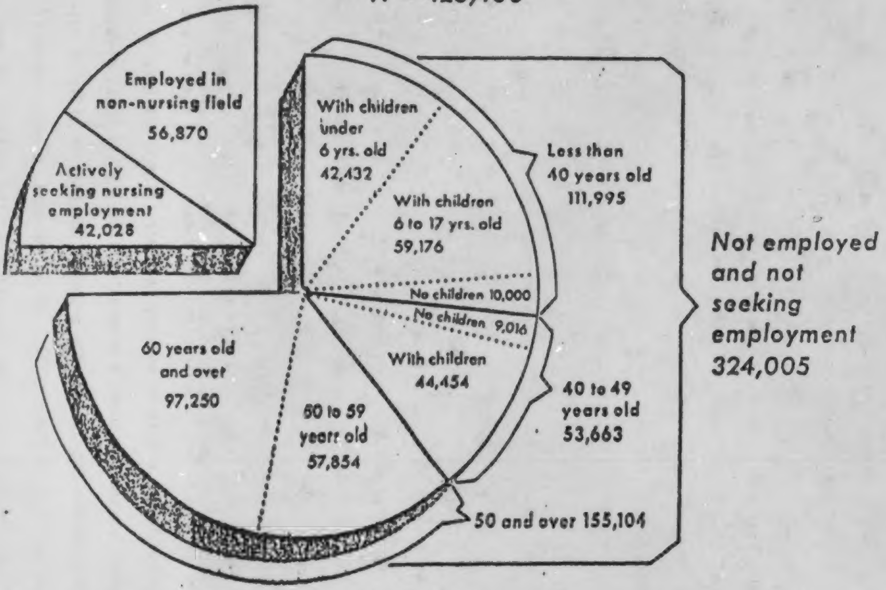
President's assurance that the matter is well in hand , experts recognize a different trend. First, in addition to the current decline in nursing school admissions, there is the simple matter of a declining birth rate which means fewer young women will be entering the employment market. Second, all indications are that there will be an ever-increasing need for registered nurses in the coming decades, estimated as some 240,000 more nurses needed by 1985 according to the Department of Labor. The growing percentage of elderly in the population, with accompanying acute and chronic health care needs, demands the expansion of health care services. The continuing improvements in health technology also require an expanding pool of skilled and experienced nurses to monitor and use this equipment. (Baltimore Evening Sun, 1 November 1979.) The manpower needs of a possible national health program have never been adequately addressed.

These newspaper articles eloquently testify to the existence of a severe nursing shortage in the country. As yet there has been no scientific study of the parameters of the issue, no systematic research into the contributing factors of the nursing shortage. It remains something of a mystery how the President can recommend nearly terminating aid to nurses training without any serious effort to understand the dimensions of the current problem or to face the future crisis in nursing manpower. There has been no grass-roots support for the President's proposal; virtually all local newspapers negatively criticize the President's proposed cut-back in articles establishing the nursing shortage in their cities. Even the most cursory review of these articles leads the reader to doubt the widsom of the President's proposal and to hope that Congress will undertake to prevent the President from intensifying an already critical shortage of nurses in the United States.

CHARACTERISTICS OF REGISTERED NURSES NOT EMPLOYED IN NURSING

September 1977

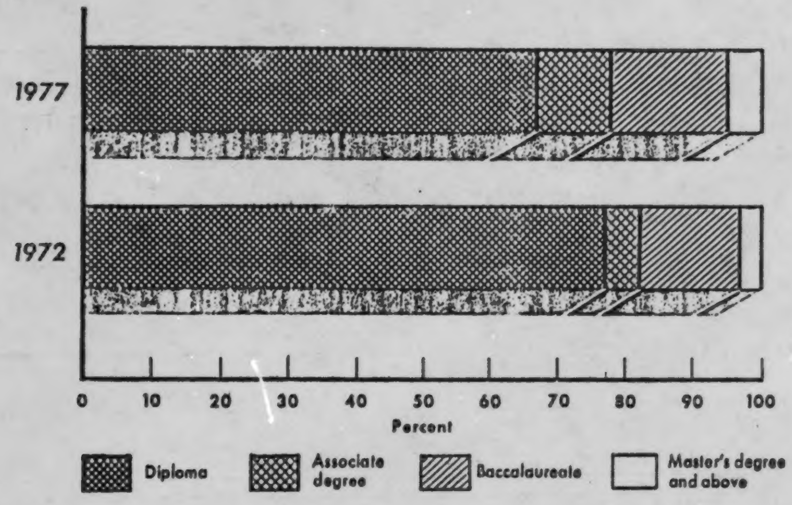
N = 423,400



Source: *1977 National Sample Survey of Registered Nurses*

Excludes those who did not indicate age or status of children

ESTIMATED PERCENT* OF REGISTERED NURSES BY HIGHEST NURSING-RELATED EDUCATIONAL PREPARATION, 1972 and 1977

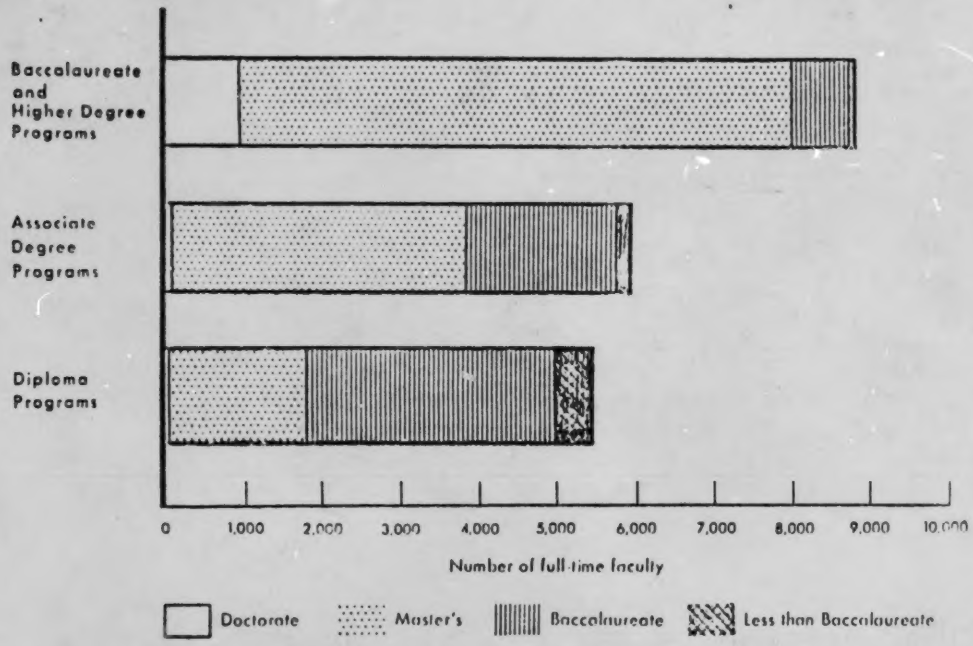


* Adjusted for nonresponse to highest nursing-related educational preparation.

Source: 1977 National Sample Survey of Registered Nurses
A Report on the Nurse Population and Factors Affecting their Supply

CHART I.7

HIGHEST LEVEL OF EDUCATIONAL ATTAINMENT, FULL-TIME NURSE FACULTY, BY TYPE OF RN PROGRAM, 1978



Source: NLN Nurse-Faculty Census, 1978

Mr. WAXMAN. We have three remaining witnesses on the schedule, and while they are not in any sense a panel, I would like to ask each of them to come forward in the interest of time, and we will hear from each witness before we go into the questions. Sally Austin Tom, nurse-midwifery educational program, School of Nursing, Georgetown University; J. Alexander McMahon, president, American Hospital Association; and Louise Esiason, R.N., Castleton State College.

STATEMENTS OF SALLY AUSTIN TOM, ON BEHALF OF AMERICAN COLLEGE OF NURSE-MIDWIVES; JOHN ALEXANDER McMAHON, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, ACCOMPANIED BY MICHAEL M. HASH, ACTING DIRECTOR, WASHINGTON OFFICE; AND LOUISE W. ESIASON, R.N., M.A., ON BEHALF OF THE FEDERATION OF NURSES AND HEALTH PROFESSIONS, AMERICAN FEDERATION OF TEACHERS, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

Ms. TOM. My name is Sally Tom. I am a certified nurse-midwife and am practicing nurse-midwifery as a member of the faculty of Georgetown University's nurse-midwifery educational program. I represent the American College of Nurse-Midwives, the professional organization whose membership includes 85 percent of all certified nurse-midwives.

According to the ACNM's official definition, a certified nurse-midwife is an individual educated in the two disciplines of nursing and midwifery, who possesses evidence of certification according to the requirements of the ACNM.

Nurse-midwifery practice is the independent management of care of essentially normal newborns and women, antepartally, intrapartally, postpartally and/or gynecologically, occurring within a health care system which provides for medical consultation, collaborative management, or referral and is in accord with the Functions Standards and Qualifications for Nurse-Midwifery Practice as defined by the American College of Nurse-Midwives.

Nurse-midwives provide prenatal care, manage labor, deliver the baby, provide care to the newborn, manage the immediate postpartum period and provide family planning and routine gynecological care to healthy women. Nurse-midwifery practice takes place within a system which provides for consultation, collaboration and referrals with physicians, nurses, nutritionists, social workers and other members of the health care team.

The Federal Government has a long history of support for nurse-midwifery education and practice. Almost all of the financial support for nurse-midwifery education has come from the Division of Nursing of HEW. Because of this strong support from the Federal Government, nurse-midwifery has grown substantially in the past 10 years. From 1931, when the first nurse-midwifery school was established, until 1970, approximately 600 people became nurse-midwives. Since 1970, the number of schools has increased from 10 to 22 basic and an additional 1,200 people have become nurse-midwives. All but one of the nurse-midwifery educational programs are part of schools of nursing and all are associated with universities.

Nurse-midwives have a proven record in reducing infant mortality. Three nurse-midwives practicing in an experimental program in rural Madera County, Calif., reduced the neonatal mortality rate from 23.9 per 1,000 live births in 1959 to 10.3 during the period January 1961 to June 1963. The nurse-midwives at the North Central Bronx Hospital in New York City have achieved a remarkable neonatal death rate of 4.2 per 1,000 working with a population which is severely economically distressed and which has a high proportion of high risk clientele.

The nurse-midwifery service in Willacy County, Tex., performs 79.7 percent of all recorded births in the county. The nurse-midwifery service clients had a prematurity rate of 3.5 percent in 1974 which compared with a rate of 7.4 percent for the Nation and 7.6 percent for Texas.

The nurse-midwifery service at New York City's Lincoln Hospital staffs an adolescent pregnancy clinic. Under nurse-midwifery care the average maternal weight gain increased to 27.916, the average newborn weight increased to 7 pounds, 12 ounces, low birth weight infants decreased to 6.3 percent.

In addition to supporting nurse-midwifery education, the Federal Government has aided extension of nurse-midwifery services to recipients of various Federal health plans, including CHAMPUS, rural health clinics and the Indian Health Service.

The American College of Nurse-Midwives would like to thank the Subcommittee on Health and the Environment for your support of the inclusion of direct reimbursement for nurse-midwifery services in the medicaid program.

The American College of Nurse-Midwives supports the passage of H.R. 6802. We are particularly pleased with the change in the residency requirements for eligibility for traineeships. All of us in nurse-midwifery education have experienced the frustration of trying to find money for students who were willing to practice in underserved areas but who were not currently living in such areas. Over half—51 percent—of certified nurse-midwives work in communities of less than 50,000 people.

In addition, we feel the special note which section 306 takes of nurse-midwives will enhance the efforts of those of us in education to put as many new nurse-midwives into practice each year as possible. We believe that the Subcommittee on Health and the Environment is making a significant contribution to the health of mothers and babies through your leadership in funding for nursing and nurse-midwifery education.

Thank you.

Mr. WAXMAN. Thank you very much.

Mr. McMahon, we welcome you to our committee and are pleased you are with us today.

STATEMENT OF JOHN ALEXANDER McMAHON

Mr. McMAHON. Thank you very much.

Mr. WAXMAN. You have a lengthy statement, and we would like you to summarize.

Mr. McMAHON. I will summarize it and speak briefly about it and keep within the time. [See p. 291.]

Mr. Chairman, as you know, I am Alexander McMahon, president of the American Hospital Association. I am accompanied by Michael Hash, the acting director of our Washington office. I want to emphasize that I am here representing the hospitals and not Duke University, but I can't pass up the opportunity, Mr. Chairman, to point out that the gentleman on your right, a professional staff member of this committee, Mr. Westmoreland, is a distinguished recent graduate of Duke University and a former trustee at the institution.

Mr. WAXMAN. If I didn't feel overwhelmed before, I certainly do now.

Mr. McMAHON. I thought, Mr. Chairman, you were being appropriately protected, both by the witnesses and by your counsel.

Mr. Chairman, in the introduction of our statement we have pointed out the need for manpower in hospitals, particularly in a day when better-trained and educated people are necessary more than ever before. Hospitals, as all of you know, have been involved in manpower education, and we are here to say the termination of educational assistance programs will have a number of difficult consequences; it will jeopardize health care programs; it will reduce the opportunity for young people for education, and it certainly will affect the hospitals' ability to provide necessary health care services.

From pages 3 to 10, Mr. Chairman, we have dealt with the nursing education situation. We have described the situation and, as Mr. Preyer noted a few moments ago, I hope we can put aside the question of whether a shortage exists or not. We have identified the shortages as best we can from the hospital side. And we have made the case for continued support for nursing education and particularly the diploma schools operated by over 300 of our hospitals.

Particularly we emphasize that because of the ability of those diploma schools to turn out nurses particularly competent at the bedside.

We have expressed our preferences, I am sure you know, Mr. Chairman, and the other members of the subcommittee who joined with you in the introduction of H.R. 6802, we have expressed our preference for that obviously, except we commented on the elimination of the scholarship program for needy students. We feel that should be continued.

On page 10, Mr. Chairman, we had comments on title 7, and we have supported capitation, of course, though we recognized in the testimony that the institutional support approach that you provided for in H.R. 6802 seems to be a quite workable alternative.

We have given attention to other provisions of H.R. 6802, as noted, and particularly the support of allied health education programs.

On page 17, I would call the subcommittee's attention briefly to some of the problems with the provisions in title V of H.R. 6802 with reference to modification of medicare and medicaid reimbursement. We are still in the process of studying that. We think there are certain problems, and with the subcommittee's permission, Mr. Chairman, we would like to submit additional comments at the completion of those studies.

On page 19, we have given attention to one of the problems in this area, the foreign medical graduates, and we are pleased an extension is proposed to the substantial disruption waiver.

As you noted in the introduction, Mr. Chairman, we have made comments about a number of other provisions. We will be glad to address ourselves to any questions you might have, but I don't think an exploration of the individual ones in this oral testimony is necessary at this stage. We stand ready to answer any questions or provide you, the subcommittee members, or the staff, with any additional information.

[Testimony resumes on p. 312.]

[Mr. McMahon's prepared statement follows:]

AMERICAN HOSPITAL ASSOCIATION
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WASHINGTON OFFICE

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION BEFORE THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT OF THE HOUSE INTERSTATE AND FOREIGN COMMERCE COMMITTEE ON PENDING HEALTH MANPOWER PROPOSALS

March 21, 1980

Mr. Chairman, I am John Alexander McMahon, President of the American Hospital Association. With me is Michael M. Hash, Acting Director of the AHA's Washington office. The AHA, which represents over 6,100 member hospitals and health care institutions, as well as more than 30,000 personal members, is pleased to have this opportunity to present its views on health manpower legislation pending before this Subcommittee.

INTRODUCTION

Hospitals are sincerely committed to the delivery of high quality, cost-effective health care services to the patients they serve. In order to accomplish this mission, there must be an adequate supply of highly qualified health professionals to meet the staffing requirements of our nation's health care institutions. Moreover, many hospitals are directly involved in educational programs for health professionals by sponsoring clinical programs for graduate medical education, operating hospital-based nursing education programs or sponsoring clinical programs for undergraduate and advanced nursing education; and conducting a variety of allied health education programs. At the present time, more than 48,000 nursing students are enrolled in hospital schools of nursing, and all nursing students receive at least part of their clinical training in hospitals. In addition, some 60,000 residents, and a substantial number of allied health professionals, receive significant portions of their educational experiences in hospitals.

CABLE ADDRESS AMERHOSP

The hospital system is, of course, a principal employer of such health professionals and, as such, is vitally concerned with federal policies affecting health manpower and, more particularly, federal financial support to manpower education.

The delivery of health care services in the hospital setting has changed dramatically in recent years. Advancements in medical practice and technology, utilization review, and the emergence of new health practitioners and institutions have significantly affected hospital operations. Patients are generally more acutely ill and their inpatient stays are shorter, and the intensity and sophistication of services have placed new demands on health professionals. Now more than ever, the educational system must be capable of meeting these challenges by having the resources to strengthen faculties, expand opportunities for clinical training, and recruit an adequate supply of qualified students.

The AHA has strongly supported existing authorities in Titles VII and VIII of the Public Health Service Act that are the foci of these hearings. We recognize the significant contribution by the federal government to the development and enhancement of programs for health professions education, and we are here today to urge continuation of these commitments. We are convinced that the cessation of federal support in this area or a precipitous decline in such aid would have an adverse impact on the ability of hospitals to meet the health care needs of their communities, and would exacerbate the problems of manpower shortages and maldistributions.

While we are aware of aggregate increases in the total supply of health professionals, we would like to point out that in certain fields, such as nursing, some medical specialties, and the allied health professions, hospitals are experiencing severe and chronic shortages. We take strong exception to the position of the Administration that federal financial assistance to medical and other health professions schools should be dramatically reduced or terminated. The loss of these federal funds would place many educational institutions in financial jeopardy, price such education out of the reach of most Americans, and adversely affect the quality and accessibility of health care services.

In preparation for these hearings, we have reviewed the Administration proposal, H.R.6800, the Health Professions Education Amendments of 1980, and H.R.6802, the Health Professions Educational Assistance and Nurse Training Amendments of 1980, introduced by Representative Waxman. In addition, we have examined the recommendations pertaining to funding for health professions education contained in the President's proposed Fiscal Year 1981 budget. Our specific comments on this legislation will deal first with proposals to revise Title VIII, authorities relating to nursing education, and second with the proposed revisions to some sections of Title VII, relating to medical and allied health education.

TITLE VIII

Nursing Education

The Nursing Shortage

Federal support to nursing education is a national issue of great concern to the AHA. Among the 6,100 hospitals which comprise our membership, 344 conduct educational programs to prepare students for professional nursing; of these, 249 form an AHA membership group, the Assembly of Hospital Schools of Nursing. Many hospitals also contribute significantly to the education of nurses in both basic and advanced educational programs by serving as clinical facilities for the practical component of such programs.

Moreover, hospitals are the major employers of nurses. A 1977 HEW-funded study revealed that more than 61 percent of the nation's practicing registered nurses (RNs) were employed in the hospital setting. It is clear that, despite alternative delivery systems and other employment opportunities, the majority of today's nurses work in hospitals.

Contrary to Administration statements that most programs of nursing education no longer require federal support because there are sufficient numbers of nurses, hospitals across the country are reporting critical shortages of nursing personnel. AHA member hospitals indicate that they have between 90,000 and 100,000 vacancies, and a recent article in Nursing '79 stated that 80 percent of the nation's hospitals currently have nursing vacancies.

Data from state hospital associations confirm this shortage. According to a recent survey of these associations, virtually every state is affected. For example, the Maryland Hospital Association reported that the state's community hospitals are suffering an average 14 percent shortage, which "cuts across all kinds of hospitals in all parts of the state." In the Baltimore area, which includes the city and five surrounding counties, the shortage was pegged at 14.8 percent. California indicated a 17 percent vacancy rate for full-time budgeted positions in its hospitals, while Texas reported that more than 12 percent of budgeted positions were unfilled. Virginia and Tennessee responded that hospitals in those states had been forced to close beds--127 in the City of Memphis Hospital System alone--in recent months due to the impossibility of obtaining sufficient nurses to provide adequate care. Georgia reported that one in eight full-time budgeted positions in the state's hospitals was vacant, and yet there were over 500 vacancies in schools of nursing this academic year. In Indiana, 84 hospitals had 1,000 vacant budgeted positions for RNs. Pennsylvania indicated 1,550 budgeted vacancies in hospitals throughout the state.

According to the Department of Labor's Bureau of Labor Statistics, of job openings in the health care field in the 1980s, up to 50 percent will be for nurses--approximately 83,000 annual openings for RNs. The American Nurses' Association cites higher figures, predicting that, by 1982, there will be a nationwide shortage of 100,000 nurses.

In spite of such shortages, the number of graduating nurses declined 2 percent in 1979--the first time in 10 years that fewer nurses were graduated than the year before--according to data from the National League for Nursing (NLN). The league also reports that applications to RN programs dropped 16 percent between 1977 and 1978. With the rate of unemployment for nurses--also 2 percent--remaining far below the norms for other categories of comparable professionals, the league predicts that the current nursing shortage will become even worse in the near future.

A recent report of the AHA's Advisory Panel on the Nurse Shortage explains that the problem exists not only in regions, states, and counties, but also within single facilities. Many hospitals reporting unfilled budgeted positions indicate greater difficulty in recruiting for evening and night shifts and for particular units--intensive care, coronary care, psychiatric, and geriatric.

Compounding the problem is the trend toward shorter lengths of stay by more acutely ill patients requiring more technologically complex nursing care. The creation of intensive care units and specialized services within hospitals has resulted in increased demand for RNs, as have changes in the utilization patterns of hospitals, with shorter stays reflecting a greater focus on the planning of admissions and discharges and a greater use of outpatient facilities. American Nurses' Association data reflect this demand, showing that hospitals have hired increasing numbers of RNs in the past few years to handle such units and services.

Special care units have developed with increasing momentum during the past three decades in response to new medical knowledge and technological advances. Specially trained nurses provide the essential minute-to-minute surveillance which permits them to function in emergency situations in lifesaving capacities before the arrival of physicians. For instance, data from one cardiac care unit indicated that prompt intervention of a lifesaving nature by nurses occurred in the cases of 32 percent of patients. For a further example: the number of nursing hours per patient day in a New York hospital's burn care center was calculated at 14, compared with the average figure of 4.5, nursing hours for a patient in a general surgical unit; a review of 1,000 admissions to the same unit during a four-year period not only showed a reduction in deaths due to burns but also a decrease in hospital stays of approximately one-third during the acute phase of burn treatment.

AHA Actions

Nursing is a priority issue on the Association's 1980 agenda. One way in which we are addressing these concerns is by sponsoring a national commission on hospital nursing services. The commission will identify issues and formulate approaches for resolving problems now being experienced by hospitals in the provision of nursing services. In doing so, the commission will focus on hospital nursing manpower requirements created by the hospital's reason for being—patient care—and its role as the primary community resource for health care. This goal will require a comprehensive analysis of the entire continuum, starting with nursing manpower planning and moving to student recruitment and selection, career development and mobility, educational preparation for required competencies, job placement and utilization, productivity and motivation, professional and economic incentives, and retention, and ending with continuing education to maintain competencies and provide ongoing professional growth.

In addition, the AHA has planned a variety of programs designed to attract nurses into hospitals, to persuade inactive nurses to return to the hospital work force, and to accentuate those in-hospital management practices that encourage the retention of nurses.

Guidelines for Federal Support

In view of the current nursing shortage crisis, the AHA believes that federal support for all types of nursing education should continue. In our opinion, the general principles governing such support should include (1) equitable distribution among the three types of basic nursing education programs and between basic and advanced nursing programs, (2) emphasis in program support on those nursing programs that provide for articulation among nursing programs, thereby offering career ladders to those in diploma and associate degree programs, and (3) encouragement of entry into the nursing profession at a time when other fields are presenting competitive challenges to occupations traditionally associated with women, such as nursing.

Capitation Grants

The AHA supports the continuation of capitation grants to all three types of basic nursing programs: diploma, associate degree, and baccalaureate degree. The elimination of such support, as proposed by the Administration in H.R.6800, would cause many of the schools to undergo serious financial difficulties. In addition, the President is expected to request a rescission of all the capitation funds currently appropriated for this fiscal year. Nursing schools are dependent on capitation funds for general support, which is vital if they are to help meet the increasing demand for more hospital-based nurses and more nurses to fill positions in alternative settings. They also are dependent on such funds for enlargement of faculties, of which there is currently a serious shortage. Without such funds, the shortage would be aggravated, resulting in cutbacks in these educational programs.

Extensive nursing manpower studies funded by HEW to project future needs under a variety of system changes, ranging from reorganization of the health care delivery system under proposals for national health insurance to reformulation of nursing roles, conclude that there will be an expansion of demand for professional nurses. Most projected scenarios call for more nurses than can be educated under current conditions, according to these studies.

The AHA is generally supportive of the alternative proposal in H.R.6802 that would continue authorization of basic institutional support, as a means of maintaining the fiscal viability of many schools. We endorse those provisions that encourage articulation programs for nurses with a demonstrated commitment to the profession who want to progress up the nursing career ladder. We also are particularly pleased to note the inclusion of provisions for equitable distribution of funding for all types of schools and for encouragement of part-time student programs to enable working nurses to enroll in programs to advance their careers while remaining in the work force.

Student Assistance

The AHA believes that the scholarship and student loan programs should be continued at current levels to assist students who may otherwise not be able to complete their educations. We support the objectives of both the Administration and Representative Waxman to increase the number of minority health professionals, a goal which would be adversely affected by H.R.6800 and H.R.6802's proposed deletion of the nursing scholarship program. An analysis of federal student assistance for FY 1974 showed that 20 percent of nursing scholarships were awarded to black students, a proportion in excess of the 2.5 percent of black nurses in active practice. The most recent figures from the NLN show a decrease in enrollments for both minority and male students in basic nursing programs. Cessation of scholarship funding would almost certainly reinforce this trend.

Scholarships have been awarded in schools of nursing to those in greatest financial need; such students are frequently from backgrounds that make it difficult for them to borrow from the private sector. Moreover, such students are not in positions both to support themselves through part-time jobs and, if the course requirements dictate, to pursue remedial and supplementary programs to help them graduate successfully.

Nursing schools report to us that as many as 80 percent of their student body may be dependent on some form of student assistance, with federal funding supplying a significant proportion of that aid. Tuition costs for nursing students also tend to be high in comparison with tuition costs for educational programs in the liberal arts, because there are frequently laboratory fees, costs of transportation to clinical sites, and exceptionally high teacher/student ratios in comparison with other undergraduate programs. The withdrawal of federal student assistance funding would be particularly hard on private nursing schools in states where public funds are available only for state institutions. Therefore, the AHA supports the provision in H.R.6802 which would extend the student loan program, and we urge the Subcommittee to adopt this provision, as well as one to continue the scholarship program.

Special Project Grants

We are pleased to note that both H.R.6800 and H.R.6802 propose to extend authority for special project grants. We support the continuation of such grants to increase the supply or improve the distribution by geographic area of adequately trained personnel; to provide more opportunities for disadvantaged or minority nurses; and to improve curricula, including those for pediatric, obstetric, and geriatric nursing. We suggest, however, that pediatric curricula stress well-child care as well as services to sick children, recognizing the benefits of preventive services for children.

We do not believe that it is necessary to provide special consideration for the development of programs of continuing education for practicing nurses, because many such programs already are offered by private organizations, or as part of inservice training within institutions. Although the AHA supports the principle of continuing education for all health care professionals, we do not consider it a national priority for federal funding.

We generally support increased federal assistance for clinical education in both basic and advanced nurse training programs. Furthermore, we stress the importance of upgrading the clinical parts of the basic education curriculum for those nurses who will enter the secondary and tertiary care systems, since the majority of nurses are employed in institutional practice, and not in primary care practice. Reports from many hospitals indicate that numerous basic nursing education programs do not afford sufficient emphasis on clinical training, which must then be provided on the job. Exposure to such training may also motivate students to choose the hospital setting as a work environment upon completion of their basic programs. Moreover, because of the increase in technology and the development of special care units, clinical training is essential at the advanced level to prepare nurses to meet the challenges of specialized nursing in the hospital setting.

We also support retention of the provision that special project grants should be available to assist in mergers between schools of nursing in hospitals and academic institutions. It is our belief that, where cooperative arrangements exist to facilitate the integration of new professionals into the work place, the retention of such professionals is higher. Such systems include joint appointments for clinical nurses as academic faculty members, supervised preceptorship and internship programs, and other such formal relationships between academic and service institutions to help close the widely-identified gap between the education and service programs.

Advanced Nurse Training

The AHA continues to support advanced nurse training programs which provide funding for three major categories: preparation of nursing faculty, the quality of whom has a direct effect on the quality of care given by students to patients; managerial education for supervisory and administrative nurses, most of whom presently rely on on-the-job training; and advanced training in specialty areas. The total repeal of this authorization, as proposed by the Administration, would jeopardize basic educational programs, where there has long been and continues to be a critical shortage of adequately-trained faculty members. Repeal also would impede efforts to deliver health care services cost effectively by increasing formal administrative training for nursing personnel. We are pleased to note that the authorization for this program would be extended by H.R.6802 at approximately current appropriation levels.

Advanced nurse training funds can encourage the development of innovative work/study programs. We wish to call to your attention a program which could be replicated in other places with advanced nurse training funds. Developed jointly by the AHA and the University of Illinois School of Nursing, the program enables practicing nursing service administrators to combine their continuing work experiences with alternating residential sessions, featuring self-learning modules supplemented by a local preceptor's instruction. Such a program, adopted nationwide, would help meet the urgent need for more formally-educated management nurses in hospitals. Such courses should be credit-carrying to enable students to attain degree status by consolidating coursework.

Nurse Practitioners

We support continuation of nurse practitioner programs, but oppose the proposal in H.R.6800 to concentrate resources in this one program, while virtually eliminating all other types of nursing support. In our opinion, with limited federal dollars available, efforts should be made to encourage balanced expansion of the total profession rather than excessive development of one discipline or specialty.

National Advisory Council

The Association opposes the dissolution of the National Advisory Council on Nurse Training, as recommended in H.R.6800. This council should be continued because the multiplicity of interests involved in nursing is too great to allow adequate representation on the proposed combined council for all health professions. Moreover, the AHA recommends that the name of the council be changed to the National Advisory Council on Nursing Education. We are pleased to note that the council would be retained by H.R.6802.

TITLE VII

Institutional and Student Support

Capitation Program

Existing law authorizes capitation grants to health professions schools to support their educational programs. These grants have provided a stable source of financial support for such schools and have served as a much-needed complement to income from tuition, voluntary contributions, and state governments.

Schools for the health professions depend upon the capitation program as a means of keeping tuition costs at affordable levels and of ensuring that students will continue to be exposed to the most up-to-date scientific and technological advancements in today's fast-changing and highly complex health care field.

Our Association is concerned that precipitous withdrawal of capitation monies from health professions schools would place many of these institutions in a state of financial crisis. Based upon the present capitation formulas, many schools have entered into binding, long-term commitments, and some could be placed in serious financial jeopardy if this source of funding were eliminated.

Therefore, we are distressed to note that H.R.6800 would repeal the present capitation authority and that the Administration's FY 1981 budget for health manpower includes no funds for capitation grants to schools of medicine, osteopathy, and dentistry, or to schools of veterinary medicine, optometry, and podiatry. Moreover, the President is expected to propose rescissions of all Title VII capitation funds currently appropriated for FY 1980. The Administration has stated that, because such schools have been anticipating the loss of such funds, they should be able to make up for this loss of support through other revenue sources. This position is unrealistic, in our view, and could lead to significant cutbacks in opportunities for enrollment in these educational institutions.

Despite the fact that we oppose the Administration's recommendations in this area, we are cognizant of the need to revise the existing capitation program. Some of the present requirements, such as across-the-board enrollment increases and minimum percentages for certain categories of postgraduate training programs, are inappropriate at this time. For example, recent figures show that enrollment in the nation's medical schools has reached a record high of 63,800 students, and by 1990 we may well have an oversupply of physicians; in contrast, however, we still are experiencing severe shortages of nurses, certain medical specialists, and some allied health professionals.

In our opinion, the approach to basic institutional support contained in H.R.6802 could be a workable alternative to the present program. The authorization would allow a level of support equal to current capitation levels.

We believe that this predictable method of financing would enable institutions to meet current commitments and to plan for and achieve their educational goals. We are pleased that this proposal would eliminate the requirement that enrollment in health professions schools increase as a prerequisite for institutional support. However, the requirement increasing the percentage of primary care residencies could have an adverse affect on the adequate supply of certain other postgraduate positions. It is important that hospitals and medical schools be able to determine the appropriate number of positions for any approved residency program, in order to take into account the resources of each institution and the characteristics of the patient population served. While we recognize the need to increase the number of primary care physicians, such an increase should not be at the expense of other necessary physician specialties.

Student Assistance

Both H.R.6800 and 6802 would retain the National Health Service Corps scholarship program, the Health Education Assistance Loan (HEAL) program, and scholarships for students with exceptional financial need. H.R.6802 also would retain the health professions student loan program, as well as traineeships for public health students, while H.R.6800 does not propose funding for either of these authorities.

We support the provisions contained in H.R.6802, which would extend current law. Student assistance is fundamental to development of the health professions. Recent increases in tuition, particularly in private schools, have made health careers unaffordable for many low- and middle-income individuals. Medical students can incur debts of up to $50,000 by the time they graduate, making them unable to establish credit for any other purpose. The reduction in federal funds that would result from termination of basic institutional support could only aggravate this situation by requiring substantial tuition increases.

Construction Authorities

Title VII authorizes grants, loan guarantees, and interest subsidies for the construction of teaching facilities for the health professions, and ambulatory primary care teaching facilities for the training of medical, osteopathic, and dental students. H.R.6800 proposes to repeal these authorities, while H.R.6802 would extend current law.

The AHA supports continuation of the authority for construction of certain educational facilities. We believe that these monies are needed not only for the construction of new schools for health professionals that are in short supply, but also for renovation and modernization of teaching facilities that are outmoded.

Of special concern to our Association are the provisions in Section 720 in current law that authorize funds for ambulatory care teaching facilities. The inadequate facilities available at some institutions have severely restricted the teaching of primary care practice. Outpatient visits, the largest proportion of which are made in teaching hospitals, increased nationally from 1970 to 1978 by 55 percent—from 137 million to 212 million visits annually. Not only has this placed an enormous strain on facilities, but it has also been a major factor in changing hospital ambulatory programs as they increasingly parallel patterns of care established in private and group practices. This change in practice patterns has frequently required modification of a hospital's structure and, in many instances, has required the creation of satellite ambulatory facilities. These trends were clearly recognized in the 17 national health priorities identified in the health planning amendments of 1979, including an increase in ambulatory services and in the affiliation of institutional providers with medical group practices. Clearly, as the AHA pointed out in testimony on that legislation, hospitals must provide space and appropriate facilities in the implementation of such principles, and in the preparation of personnel to carry out these new tasks effectively. Therefore, we strongly recommend continuation of funds under this authority, which neither H.R.6800 nor H.R.6802 would extend.

Project Grants and Contracts

Title VII contains a variety of categorical authorities which relate to area health education centers (AHECs), primary care education, access of disadvantaged persons to health careers, allied health education, public health education, and health administration. We would like to comment on some of the provisions contained in the bills before the Subcommittee that would extend these authorities.

Area Health Education Centers

Section 781 of the existing law authorizes the development of AHECs for the conduct of graduate, postgraduate, and continuing education programs in medically underserved areas. We are pleased that both H.R.6800 and H.R.6802 would continue this program at its present level of funding. In our opinion, AHECs have been used effectively to meet the health care needs of rural areas, while serving as mechanisms to encourage health care practitioners to locate and remain in underserved areas. In fact, the AHA recommends modifying present authority to encourage the establishment of AHECs in urban underserved areas as well.

Allied Health Personnel

Under existing law, grants are available to health professions schools, states or political subdivisions of states, and other public or nonprofit entities to assist in planning and operating allied health education programs. Special emphasis is placed on projects that coordinate education and training programs among the health professions, as well as on programs that establish new roles and functions and meaningful career ladders for allied health personnel.

The Administration's FY 1981 budget, citing the pending oversupply of health professionals, proposes drastic cuts in funds for allied health education. It is our view that this drastic decrease in funding is unwarranted. We do not concur with the Administration's claim that there now is a pending oversupply of allied health professionals--a claim that is inconsistent with a preliminary HEW report on allied health personnel which reflects widespread shortages and cites programs in some states that are having problems in recruiting students. Such recruitment problems are bound to increase, particularly if predictions materialize that the 18 to 24 age group in our population will decline in number substantially in the coming years and there will be a smaller pool of potential students from which to draw. Rather than an oversupply of allied health professionals--as a result of the emphasis in the existing statute on the development of new roles and types of health practitioners--there has been a proliferation of such personnel who are highly-specialized. It is this over-specialization that we believe is unwarranted. A striking example is in the category of cardiology technologists/technicians in which nine subcategories are identified in the 1979 edition of The Health Careers Guidebook jointly prepared by the Departments of Labor and HEW. These subcategories did not exist a decade ago.

Finally, we consider it irresponsible of the Administration to suggest that state and local governments will be able to compensate for the proposed drastic cuts in funding for health professions education at the federal level. Given the present state of the economy and the financial difficulties of many of our major urban institutions--where a majority of programs for the training of allied health professionals exist--severe curtailment of federal funds would be certain to undermine valuable educational resources.

We are pleased that H.R.6802 would continue the present program of project grants to educational institutions for training allied health personnel. Existing law authorizes a program of project grants and contracts that includes hospitals affiliated with educational entities among those eligible for participation, and we believe it is important that such a program be retained. At the present time, approximately 1,100 hospitals provide clinical facilities for more than 7,000 allied health programs in educational institutions, and they cannot meet completely the costs of training allied health professionals through patient care revenues. In fact, some third-party payers have placed limitations on their hospital payments for education. Hence, it is important that hospitals and other clinical sites be eligible for grants related to such projects.

We are pleased that H.R.6802 would continue funding for schools of public health and graduate programs in health administration.

We also want to note our support for the new Section 794, proposed in H.R.6802, that would authorize the Secretary to make grants to and enter into contracts with entities to establish mid-career educational programs in public health and health administration. We believe this proposal will enable many supervisory personnel, who often assume administrative responsibilities after having performed in a clinical capacity, to obtain needed managerial skills.

National Health Service Corps

Title I of H.R.6802 would revise and extend the authority for the National Health Service Corps and the corps scholarship program. The AHA supports the work of the corps and views it as a primary force in meeting the needs of medically underserved areas. We have been working with HEW to encourage the assignment of corps personnel to primary care programs sponsored by urban and rural hospitals, and urge that the Subcommittee endorse such efforts both through direct assignments and private practice option approaches.

In this regard, we are especially pleased about two aspects of Title I. First, under Section 101(b)(2), entities in health manpower shortage areas seeking to have corps scholarship obligees assigned to them could apply for and receive grants to enable them to pay the obligees salaries equal to civilian employees of the corps. Often, health care institutions that provide large amounts of uncompensated care are unable to pay competitive salaries for physicians and other health personnel, a factor that contributes to their need for corps support. We believe it is important for persons serving in health manpower shortage areas to receive equitable compensation, in part to encourage them to view their obligated service as within the mainstream of medical practice. Such encouragement could play a significant role in the retention of personnel in shortage areas.

In addition, we support Section 101(b)(3) of H.R.6802 (and a comparable provision in Section 10 of H.R.6800) which would permit the Secretary to conduct cooperative programs with state and local governments and other public and nonprofit private entities to reduce the geographic maldistribution of primary care health professionals through the use of corps personnel. Under these programs, the Secretary would assign corps members to entities within the states in accordance with locally-developed plans for the delivery of primary health care in health manpower shortage areas. This cooperative program could be of significant value to certain urban and rural hospitals whose difficulties in attracting and retaining qualified personnel are, in some measure, the result of economic, social, and political factors beyond their control. It is our position that state and local entities can best determine the nature and extent of health manpower shortages. The problems of professional maldistribution, therefore, will be adequately addressed only if state and local governments are encouraged to participate in the planning and development of solutions.

Family Practice/Primary Care Authorities

A major goal of the Health Professions Educational Assistance Act of 1976 was to increase the numbers of primary care physicians and to encourage such practitioners to practice in medically underserved areas of this country. Toward that goal, the law authorizes several programs for grants to medical and osteopathic schools, as well as to hospitals, for the construction and operation of facilities for departments of family medicine; for the operation of training programs in that specialty; and for scholarships, fellowships, and stipends to interns, residents, and other medical personnel who participate in family medicine residency programs. In the past, these programs have been well-funded; for FY 1981, an increase of $18 million has been requested by the Administration.

Both H.R.6800 and H.R.6802 would retain existing authorities for grants to establish and maintain residency programs in family medicine, general internal medicine, and general pediatrics, and would amend the statutory language to include hospitals in addition to medical and osteopathic schools. In view of the fact that many hospitals already are the loci for such residency programs, we strongly support this change.

Nonetheless, while we believe that the number of primary care residency positions should be increased, we do not support accomplishing this goal at the expense of other necessary postgraduate positions. As we stated earlier, it is important that hospitals be able to determine the appropriate number of positions for any approved residency program, taking into account the resources of each institution, the characteristics of the patient population served, and the availability of teaching physicians. To do otherwise could require some institutions to experience serious physician shortages that would have an adverse impact on the delivery of needed care and significantly increase the cost of that care by requiring contractual arrangements with physicians from established private practices.

Medicare/Medicaid Reimbursement for Primary Care Residents' Services

Title V of H.R.6802 would allow hospitals to elect alternate methods of payment for outpatient services furnished to Medicare and Medicaid patients by primary care residents. Under current law, services of residents performed in hospital outpatient departments are covered under Part B of the Medicare program, not as physicians' services but as part of hospitals' general outpatient services. The reimbursement is 100 percent of reasonable cost, of which 80 percent is paid by Medicare and the remaining 20 percent by the beneficiary. Comparable services under Medicaid are not required to be paid on a cost-related basis and in many states are subject to arbitrary ceilings.

Title V would permit payment for these services under Medicare, either on the current reasonable cost basis or on a charge basis, the same as for other physicians' services. Title V would also require states under the Medicaid program to pay for these services on a cost-related basis at a level equal to 100 percent of reasonable and related costs.

The proposed Medicaid change would provide financial incentives for the development of additional primary care residencies to serve these patients. A significant volume of hospital outpatient services--representing a significant increase during the last decade--are provided in teaching hospitals. Many of these services are provided to Medicaid patients at less than reasonable cost.

However, these Medicaid changes would have another significant effect. Many of the affected institutions will be among the financially distressed public and private hospitals in urban areas of our country. As you know, Mr. Chairman, these hospitals provide large amounts of uncompensated care, especially outpatient services, and do not always receive full cost reimbursement for such care. The Medicaid changes proposed in Title V would help these facilities meet more effectively their patient care responsibilities. While only a partial solution to the total problem of underpayment of care, the payment of full reasonable costs for these services under Medicaid could contribute significantly to both the short- and long-term relief of such financially distressed hospitals. In addition, payment on a cost-related basis under Medicaid would have the added benefit of shifting the incentives for, and the focus of, health services provided to Medicaid beneficiaries from the inpatient setting to the less costly outpatient setting.

We are still reviewing the full impact of the proposed changes under Medicare and Medicaid, and will be pleased to furnish the Subcommittee with additional comments on these provisions at a later date. We strongly support the proposed improvement in Medicaid reimbursement; however, we have reservations about the detailed provisions of H.R.6802 that would implement this approach and believe that further clarification is essential. We will be pleased to work with the Subcommittee in clarifying and, if necessary, modifying the proposed language.

Foreign Medical Graduates

Both H.R.6800 and H.R.6802 would extend the "substantial disruption" waiver provision of section 212 of the Immigration and Nationality Act to December 31, 1983. Existing law permits teaching hospitals to request a waiver of certain provisions of the act which limit the participation of foreign medical graduates (FMGs) in U.S. graduate medical education programs if it is shown that exclusion of an alien medical graduate from the program through application of the requirements would cause a substantial disruption in the health services provided by the hospitals. Under current law, this waiver provision expires December 31, 1980.

The AHA strongly supports this proposed extension. The availability of this waiver is of critical importance to certain major urban health institutions. As you know, many hospitals, both public and private, are experiencing severe financial difficulties as a result of the volume of uncompensated services provided to residents of urban areas without health insurance coverage or eligibility for public programs. A significant side-effect of this problem is the decreased ability of these hospitals to retain medical staff and to maintain graduate medical education programs. As financial conditions worsen, salaries in these hospitals cannot keep pace, and the ability of the institutions to maintain the equipment and support services required by physicians in specialty practices becomes severely limited.

A recent New York Times editorial noting that the termination of the substantial disruption waiver would intensify the hospital financial crisis in New York City stated that hospitals would be forced either to reduce services or incur further costs in attempts to attract U.S. physicians to replace the foreign physicians in training. Those most likely to suffer, the editorial concludes, would be the poor who rely on housestaff as their family physicians.

The AHA also supports the provision in H.R 6802 which would extend the length of time for which FMGs are permitted to come to the United States for training from the existing two years to seven years. The proposed change would recognize that many postgraduate programs require more than two years to complete.

Moreover, we encourage the Subcommittee to adopt the provision in S.2378, introduced by Senator Javits, that would (1) permit a National Health Service Corps scholarship recipient to fulfill his or her obligation by voluntarily performing his or her residency in a hospital where residency training programs are heavily dependent on FMGs and (2) designate a hospital with a heavy dependence on FMGs as constituting a highest priority health manpower shortage area for purposes of assigning corps personnel (and limit the cost-sharing obligation of the hospital in such a case to a salary equal to that which was paid to the FMG resident). We believe this approach would help to alleviate the problem of reliance on FMGs. In addition, it could encourage physicians to establish practices in underserved urban areas, thereby helping to ameliorate the chronic physician shortages in these localities.

Data Requirements

Accurate, comprehensive data on health manpower are fundamental to the development and maintenance of a meaningful national health manpower policy. The existing cooperative health statistics program was developed with this goal in mind. Unfortunately, uneven development and technical problems have limited the program's usefulness. While some states have excelled in data collection efforts, others have performed poorly, and still others have not participated at all. As a result, data are often incomplete or inaccurate, and meaningful comparisons or compilations cannot be made. Both public and private efforts to address manpower policy questions have been hindered by this problem.

The AHA believes that any program of health manpower data collection must be supported by a commitment of resources from the federal government, and we are pleased that both H.R.6800 and H.R.6802 would continue this authority. This commitment is necessary to ensure a uniformity of effort. One of the most important additional resources that the federal government can provide is a strong technical assistance program to enable those states without adequate capabilities in the data field to acquire the necessary expertise.

We are concerned, however, that H.R.6800 would exempt these data collection efforts from the requirement for coordination of federal reporting services, which is intended to minimize the burden of federal reporting systems on small businesses and other organizations. Often efforts by federal agencies to obtain needed information result in an unnecessary duplication of effort for the public, and this is especially burdensome for smaller organizations that may not be able to devote the necessary manpower and time for compliance. Our Association has long supported proposals aimed at reducing these burdens, and we do not believe it is appropriate to exempt these data collection efforts from this requirement.

We would also like to point out that hospital-based manpower is one area of particular deficiency in existing health manpower data efforts. Federal and state programs have not focused on the need to identify and describe those practitioners who are located in the hospital setting and to determine requirements for such personnel. One result of this deficiency has been difficulty in determining, from existing data sources, the shortage of nurses in hospitals, in terms of the overall supply of nurses.

The AHA recommends that particular attention be given to this data deficiency. We further recommend that this data collection be accomplished in cooperation with the efforts of the private sector, including those of the AHA. Existing expertise and data channels make such an alternative preferable to an independent public sector effort.

Advisory Councils

We already have noted our opposition to the provision in H.R.6800 that would dissolve the National Advisory Council on Nurse Training and provide for nursing representation on the National Advisory Council on Health Professions Education. However, our Association would support consolidation of all other advisory functions under Title VII, with assurance of appropriate representation from all affected professional groups. In addition, the AHA recommends that representatives of employers of health professionals be included on the council. This representation would provide a significant link between educational objectives and the employment marketplace.

We are pleased that H.R.6802 would establish an independent statutory authority for the Graduate Medical Education National Advisory Committee (GMENAC); currently, GMENAC exists under a general grant authority to the Assistant Secretary for Health. Our Association supports the charge to GMENAC (contained in Title IV of the bill) that it study and make recommendations with respect to the geographic distribution of physicians, including factors such as reimbursement and financial support for graduate medical education which may affect locational decisions.

CONCLUSION

Mr. Chairman, on behalf of the AHA, I would like to thank this Subcommittee for the opportunity to present our views on pending health manpower proposals. We would be pleased to offer any further assistance, at your request, and to respond to any questions which you or other members of this Subcommittee may have.

Mr. **Waxman**. We appreciate your help.

I would like to hear from Ms. Esiason.

STATEMENT OF LOUISE W. ESIASON, R.N., M.A.

Ms. **Esiason**. Mr. Chairman, I am here to represent the Federation of Nurses and Health Professionals and the American Federation of Teachers, AFL-CIO, an organization of over 550,000 teachers, paraprofessionals, nurses, and allied health professionals, all of whom are directly concerned with the health care services in this country.

The health manpower proposals set forth before this committee attempt to address an extremely complicated set of problems. The problems of education, distribution, recruitment, retention, and utilization of nurses and other health professionals have become more acute as the cost of providing quality health care service increases.

Reflecting upon all the aforementioned problems and the concerns voiced by our membership, we submit the following summary comments on nurse education funding for your consideration. We ask the committee to consider a 5-year funding bill to stabilize funding and to have adequate time to thoroughly research the marketplace, collect and analyze data about the use of funds, distribution and retention of health professionals, and utilization of nurses and other health professionals already in the marketplace. We argue that a major cut in funding this year on top of a 50-percent funding cut last year totally disrupts the education and employment networks for nursing and other health professionals.

Moneys provided for capitation incentive grants should be based both on full-time and full-time-equivalent students, because of an increasing trend toward part-time education. This is extremely important since part-time educational programs will meet the needs of minorities and disadvantaged individuals.

Since we all may realize that this type of capitation support is unlikely to continue forever, we question this proposal which increases funding over the next 3 years. Why not start now with the higher level of funding—as proposed for fiscal year ending September 1983—and then decrease those funds by 10 percent each year to make an eventual phaseout a less dramatic loss. There should also be a mechanism developed for accountability in the use of capitation funds so as to insure program enrichment rather than just support for administrative costs.

Availability of increased funding for special projects which provide for LPN's and RN's to continue their education is strongly supported. These men and women who return to school are highly motivated, have a tendency to stay in the workforce longer and are most likely to continue their education through the master's level and beyond. Support for education to allow nurses to re-enter practice is invaluable since technological change in the industry continues and these individuals need incentives to go beyond some of the reasons which cause nurses to leave practice, such as child rearing and poor working conditions.

We assert a strong belief that nursing education has consistently improved, and that the quality and amount of supervised clinical practice has increased over the years. We support any efforts aimed at further improvement of clinical practice.

We urge continued funding of traineeships at their present levels. The shortage of qualified personnel for administrative, educational, and research positions remains acute.

Loan forgiveness should be tied to length of time the nurse remains in practice as well as time served in areas of priority need for nursing care.

Legislative intent over the next 5 years should encourage grants and scholarships for the 75 percent of nurses who are having difficulty upgrading their skills through BSN programs. Nurse practitioners and nurse anesthetists often earn wages that are far in excess of the staff nurse, and they are better able to repay loans. The federation believes that higher earning capability and loan availability should be incentive enough to encourage enrollment in nurse practitioner and nurse anesthetist programs. Competition for admission to these programs is great, which proves this point.

Despite the statistical numbers game often discussed by the administration, the Bureau of Labor Statistics, and the Department of Health and Human Services regarding nurses, the facts in the marketplace reveal a shortage of practicing nurses. The federation maintains a firm belief that problems of nurse retention are directly related to the need to control wages, benefits, working conditions and patient care through collective bargaining. We also recognize that without continued Federal support, there will continue to be a shortage of practicing nurses.

We thank the committee for the opportunity to present our viewpoints.

[Ms. Esiason's prepared statement follows:]

STATEMENT OF LOUISE W. ESIASON, R.N., M.A.

I am here to represent the Federation of Nurses and Health Professionals and the American Federation of Teachers, AFL-CIO, an organization of over 550,000 teachers, paraprofessionals, nurses, and allied health professionals, all of whom are directly concerned with the health care services in this country. The following comments represent a summary of the Federation's full statement which will be forwarded to the committee for the record.

The health manpower proposals set forth before this committee attempt to address an extremely complicated set of problems. The problems of education, distribution, recruitment, retention, and utilization of nurses and other health professionals have become more accute as the cost of providing quality health care service increases. In nursing service alone, an article in Nursing 79 indicates that 80% of hospitals in this country are experiencing nurse shortages.

Reflecting upon all the aforementioned problems and the concerns voiced by our membership, we submit the following summary comments on nurse education funding for your consideration:

Duration and Funding of the Bill

We ask the committee to consider a five year funding bill to stabilize funding and to have adequate time to thoroughly research the marketplace, collect and analyze data about the use of funds, distribution and retention of health professionals, and utilization of nurses and other heath professionals already in the marketplace. We argue that a major cut in funding this year on top of a 50% funding cut last year totally disrupts the education and employment networks for nursing and other health professionals.

Capitation Incentive Grants

Monies provided for capitation incentive grants should be based, in both baccalaureate and associate degree programs on full-time and full-time equivalent students because of an increasing trend toward part-time education. With increases in the cost of education and in the cost of living itself, more and more students find it necessary to work and therefore cannot handle full-time enrollment. New completely part-time associate degree programs created to meet the needs of these individuals cannot get funding without the addition of full-time equivalence in determining the enrollment in associate degree programs. This is extremely important since part-time educational programs will meet the needs of minorities and disadvantaged individuals.

While we all may realize that this type of capitation support is unlikely to continue forever, we question this proposal which increases funding over the next three years. Why not start now with the higher level of funding (as proposed for fiscal year ending September 1983) and then decrease those funds by 10% each year to make an eventual phase-out a less dramatic loss. There should also be a mechanism developed for accountability in the use of capitation funds so as to ensure program enrichment rather than just support for administrative costs.

Availability of increased funding for special projects which provide for LPNs and RNs to continue their education is strongly supported. These men and women who return to school are highly motivated, have a tendency to stay in the workforce longer and are most likely to continue their education through the masters level and beyond which in turn helps meet critical needs for administrators, supervisors, educators and researchers. Support for education to allow nurses to re-enter practice is invaluable since technological change in the industry continues and these individuals need incentives to go beyond some of the reasons which cause nurses to leave practice, such as child rearing and poor working conditions.

We assert a strong belief that nursing education has consistently improved, and that the quality and amount of supervised clinical practice has increased over the years, not decreased. We support any efforts aimed at further improvement of clinical practice. For example, there are increasing opportunities for internships for graduate nurses which, hopefully, will address this goal. To assure access to these programs, loan repayment deferals should be available to nurses serving internships just as they are to other health professionals, including physicians. Loan repayment deferals for these internships should be provided for nurses enrolled in programs offered by institutions of higher learning to make sure that they meet the needs of the students first and the service requirements of the health institutions second.

We urge continued funding of traineeships at their present levels. The shortage of qualified personnel for administrative, educational, and research positions remains accute. (At my own college three faculty positions were advertised for several months with only one marginally qualified applicant response.) However, when 75% of all nurses in this country are below the baccalaureate level, there is an enormous need to increase their access to education. Obviously, the number of nurses available for graduate study is limited.

Availability of loan forgiveness should be tied to length of time the nurse remains in practice as well as time served in areas of priority need for nursing care, both in state and out of state. The ability to repay the loan based on salary earned should be considered. While we support the concept of service in exchange for financial assistance, many who enter nursing studies will be unable to leave their home area for personal reasons. It has been demonstrated that providers indigenous to an area are better equiped to deal with the problems of that area and therefore availability of in-state service should be added.

Legislative intent over the next five years should encourage grants and scholarships for the 75% of nurses who are having difficulty upgrading their skills through BSN programs. Nurse practictioners and nurse anesthetists often earn wages that are far in excess of the staff nurse and they are better able to repay loans. The Federation believes that higher earning capability and loan availability should be incentive enough to encourage enrollment in nurse practicitioner and nurse anesthetist programs. Competition for admission to these programs is great, which proves this point.

Grants available to schools of medicine, osteopathy, dentistry, and veterinary medicine, etc., which enable them to meet the cost of recruitment of women should also be available to schools of nursing to meet the cost of recruitment of both men and women. With 100,000 unfilled nursing jobs in this country and overall applications to nursing programs declining, we are apt to encounter greater shortages unless funding to support recruitment efforts is forthcoming.

Despite the statistical numbers game often discussed by the Administration, the Bureau of Labor Statisitics, and the Department of Health and Human Services regarding nurses, the facts in the marketplace reveal a shortage of practicing nurses. While the Federation maintains a firm belief that problems of nurse retention are directly related to the need to control wages, benefits, working conditions and patient care through collective bargaining, we also recognize that without continued federal support to correct utilization of nurses in the health care marketplace there will be a shortage of practicing nurses.

We thank the committee for the opportunity to present our viewpoints.

DATA COLLECTION AND ACCOUNTABILITY

Uniformity of efforts in developing comprehensive data on health manpower is fundamental to implementation of this nation's health planning policies. The federal government has every right to know how its dollars are being spent. Data collection which is centralized and comparable between schools, health care facilities, state and local governments and health planning agencies is a necessity if we are to determine ways to match available health resources with this country's relatively high unmet level of consumer needs for access to health care service.

While public educational institutions and public health care facilities have open reporting mechanism, the bulk of the health care industry is privately owned. Until the private sector of the health care industry jointly cooperates with the government, for specified collection of utilization, retention and economic data on health manpower, there can be no base for future judgement.

One deficiency the Federation recognizes in current data collection is lack of information on hospital work settings where over half of all nurses and allied health professionals are employed. One area of specific concern reflects retention problems of hospital-based health professionals.

The Federation suggests the Committee consider Federal support for a uniform data collection network operated through already existing health systems agencies. We feel that the HSAs are already looking at geographic distribution of health services, community health needs and appear to be the obvious clearinghouse for analyzing use of health manpower resources.

NATIONAL ADVISORY COUNCILS

The Federation supports cooperative efforts between the existing national advisory councils on education for nurses, other health professionals and graduate medical students. However, we also recognize that each advisory council has a unique role to play in the health planning process and therefore, should be allowed to exist separately in order to meet specific needs for those three areas of health manpower. We recommend that the name of the advisory council for nursing be changed to the National Advisory Council on Nurse Education and that membership on that council specifically include student nurses, AFL-CIO nurses and licensed practical nurses.

FOREIGN NURSE GRADUATES

Use of foreign nurse graduates by the hospital industry in this country does not answer the long standing and continued problem of nurse shortages. The influx of foreign nurse graduates erodes the existing nurse labor force in this country. In fact, the practice of using foreign nurse graduates denies employment to U.S. minority groups, promotes a subtle form of indentured servitude and comprises quality patient care. Use of foreign nurse graduates who have not met U.S. licensing standards is promulgated by vested interests who spend large amounts of money to recruit and import these nurses. If comparable resources were spent to improve present working conditions, hospitals would have no difficulty in finding U.S. qualified nurses for employment.

AREA HEALTH EDUCATION CENTERS

The continued support for development of AHECs is strongly supported by the Federation. It is our collective opinion that AHEC education programs which meet health care needs in rural areas should be expanded to also reflect growing needs in underserved urban areas. Further, the Federation believes strongly that AHECs present logical vehicle to greatly expand health education programs to citizens residing in a given AHEC region.

ALLIED HEALTH PROFESSIONALS

Federal grants to education programs for existing catagories of allied health professions should be continued at its previous level. While primary emphasis is with basic education programs among health professions, new incentives for programs which develop career ladders should be fostered. Health profession education programs, both at the community college and university level rather than in hospital based programs, will enhance development of a career ladder approach.

Mr. **Waxman**. Ms. Tom, is it difficult for nurse midwives to find placement? What is a particular service setting?

Ms. **Tom**. There are many more jobs available to nurse midwives than there are midwives to fill them. The problem arises in that often jobs are available which do not include the full scope of the midwifery practice. A health department may wish to hire one to give prenatal care and postpartum care, but is unable to, or unwilling to do the negotiating that allows them to have full privileges. So many of those jobs are unopen to us because we do want to practice fully.

Mr. **Waxman**. Mr. McMahon, it is argued that much of the retention problem in the nursing work force arises from low salaries and benefits, and nurse registries charge high bounties to the hospital for finding each nurse. If there is a nursing shortage, why has the salary not risen accordingly?

Mr. **McMahon**. I am pleased to have the opportunity to educate two members of the subcommittee on cost containment, Mr. Chairman. In the voluntary effort that we mounted, the American Hospital Association, the Medical Association, the Federation of American Hospitals and other parts of that coalition, have been preaching the necessity for cost containment. If in preference to continued support for nursing education programs you would rather that we expand the salaries, I would trust that some appropriate direction would be given to us so that we can at least take that into account at our cost containment activity.

Mr. **Waxman**. I am worrying that you are containing costs by paying nurses lower wages than they should receive, and that that is why we have a shortage.

Mr. **McMahon**. The American Hospital Association is in the process of putting together a special committee on hospital nursing. We are not sure; we do know that nursing salaries had risen substantially in the late 1960's and the early part of the 1970's. We have been trying to adhere to the President's wage guidelines. If we were to make a substantial move—and quite frankly I have been talking against it because of the pressures for cost containment—if we were to make a substantial move, we are not sure that it would work, first, and obviously it would have grave implications for cost containment, itself.

What we want to do in this special committee that I mentioned, Mr. Chairman, is to look at a lot of things, salary and compensation, working conditions, what kind of status problems there are, and how might we best attract more nurses, again in a cost containment era.

I know of your interest in that, as I do Mr. Preyer's and Dr. Carter's, but to try to balance in this difficult inflationary era, to try to balance additional costs and the benefits we gain for it, and as we come to some conclusions, even tentative, we will be glad to pass those on to the subcommittee.

Mr. **Waxman**. Thank you. We look forward to receiving those.

Ms. Esiason, you suggest we should begin our institutional support program at the highest level and then decrease funding. Would you support a decline in, and eventual removal of, Federal support for nursing education?

Ms. **Esiason**. I don't think we will ever be able to do without it, but history shows us it has been declining. The funding dropped 50 percent last year and will drop significantly more this year. I realistically hope this will change in the future. That is my problem. I am afraid it is a reality. I don't think it bodes well for nursing.

Mr. **Waxman**. But if you knew, in fact, there were to be continued funding, then you would not——

Ms. **Esiason**. I wouldn't feel this way, but now it is difficult, when an institution depends on support and suddenly finds funds are cut in half; it is very difficult to continue with the same quality program that you have had in the past.

Mr. **Waxman**. If there is a nursing shortage, why do you suggest we divert even more Federal money into upgrading working nurses' education rather than toward training as many new nurses as we can?

Ms. **Esiason**. I think as the last panel mentioned, skills, higher and higher expectations of nurses, exist all the time, and that we need more and more skills. We need more and more people trained at higher levels.

Mr. **Waxman**. Thank you very much.

Dr. Carter?

Mr. **Carter**. Thank you, Mr. Chairman.

Have you noticed any significant change in trends with respect to the retention of nurses in hospital-based employment?

Mr. **McMahon**. Not any significant changes, Dr. Carter. I think that what we have seen, as the supply has gradually increased, is a jump in the need for nurses and, of course, other technical trained people in the hospital, as our services have gotten more sophisticated, and more technologically intense. So we are convinced, and I tried to note in the testimony, we are losing ground on the staffing side for that reason.

Mr. **Carter**. What are your institutions doing to keep high quality nursing personnel in your workforce?

Mr. **McMahon**. Dr. Carter, they are doing a number of things, some of them, I think, better and more productive than others. We are concerned about the movement to nursing registries, but we understand some of the reason of flexibility that is involved in it. We have been, and have commented about, the various things we have done in recruitment, including the recruitment of nurses from foreign nursing schools.

We have taken a look at the compensation and fringe benefit plans, and have taken a look, too, at the staffing patterns. A lot depends on the situation. It isn't uniform across the country, and, again, I referred earlier to the special committee we are creating; it will be a mechanism, Dr. Carter, through which we can find who is doing what and who is having the greatest success, because hospitals across the country are doing all kinds of things to attract nurses into nursing, to attract some of those who have been out, training some of those who have been out, and would like to upgrade as well as to continue to recruit and preach the story of nursing to young women considering their career.

Mr. **Carter**. Ms. Esiason, what concerns do you have with regard to the immigration of foreign nurses, and what changes in the current policy do you recommend?

Ms. **Esiason**. My concern is a lot of foreign nurses may be recruited to fill positions that we could better fill with our own nurses who we can maintain some assurance of quality of their preparation, and we don't have this ability with foreign nurses.

Mr. **Carter**. What about FNG's, the foreign nurse graduates? Is their training up to our schools' standards?

Ms. **Esiason**. In my own experience, no. It is limited, but we have had occasion to admit a number of foreign nurses to our program to complete requirements before they can even take State boards. Their own education has some deficiencies in it which they have to make up before they can take State boards, and they have had a great deal of difficulty, even with the requirements of our program.

I admit this is limited experience, but it is not——

Mr. **Carter**. Mr. McMahon, what is your comment on that?

Mr. **McMahon**. We have obviously a quality concern, but I know from talking to some of the hospital people that in their screening, they are finding qualified and capable foreign trained nurses to augment their nursing staff. I have seen it across the board, not only in the nursing positions but in other positions, teaching positions, administrative positions, including one of our own at the American Hospital Association.

When you balance off the shortage, Dr. Carter, with the capable young people we are finding, and providing additional training opportunities for, we are quite satisfied that it is a useful source.

Mr. **Carter**. Who pays the cost of continuing education for nursing personnel at your hospitals?

Mr. **McMahon**. I suspect in the most part, I am not precisely certain, but episodically from what I know, Dr. Carter, the hospital, itself, will, just as it provides educational opportunities for other people on the hospital staff. I would guess it is more likely to be that than the nurse, herself, though in some cases I suspect leaving the hospital setting and going to full-time schooling, she may be doing some of it, or may be finding some scholarship help as well.

Mr. **Carter**. By the way, I happen to have a school of midwifery in my home district.

Thank you.

Mr. **Waxman**. Thank you, Dr. Carter.

Mr. Preyer?

Mr. **Preyer**. Thank you. I am sorry, Congresswoman Mikulski wasn't here to hear your testimony, Ms. Tom; I know she would be very impressed, as I think all of us are with the statistics which you cited here. It is very impressive.

Ms. **Tom**. Thank you.

Mr. **Preyer**. I really have no further questions. I do think on the question of nurses' salaries, part of the problem may be what I think Dean Wilson mentioned, the old tradition that this was women's work, and therefore ought to be paid at a cheaper rate, is one that is going to be hard to overcome in this field, but I really think we need to do something, and we will look forward to your suggestions on it, Mr. McMahon.

I am hoping that costs can be held down, like everyone else. We hope that wise use of expensive medical technology can offer some of the solutions for that rather than penalizing the nurses.

Mr. **Carter**. Would the distinguished gentleman from North Carolina yield on that?

Mr. **Preyer**. I yield to the gentleman, and I hope I didn't make a cutting remark.

Mr. **Carter**. I must say that you are a gentleman of high quality and always have been.

I wanted to ask you, can the economy of one segment of our society be controlled and not all segments? Can we have wage and price controls in hospitals and not have them throughout our country?

Mr. **Waxman**. Let me interrupt and say the answer is going to be no. Whether it can be done or not, the answer is that I don't expect it will be done.

Mr. **Preyer**. I think that is probably right. It would be very difficult, Dr. Carter.

Mr. **Waxman**. Let me thank my colleagues for participating in the meeting and thank you all for being with us. Your testimony has been very helpful. We will look at the written statements as we evaluate the specifics of the bill we have before us. We look forward to working with you on it. Thank you.

We will meet on Monday, at 10 o'clock in this room for continued hearings on the health manpower issue.

[Whereupon, at 12:10 p.m., the subcommittee adjourned, to reconvene at 10 a.m., Monday, March 24, 1980.]

HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE AND NURSE TRAINING ACT OF 1980

MONDAY, MARCH 24, 1980

House of Representatives,
Subcommittee on Health and the Environment,
Committee on Interstate and Foreign Commerce,
Washington, D.C.

The subcommittee met pursuant to notice, at 10 a.m., in room 2322, Rayburn House Office Building, Hon. Henry Waxman, chairman, presiding.

Mr. **Waxman**. The meeting will come to order.

Today the subcommittee continues its hearings on the health manpower legislation. This morning our witnesses will discuss primary care and the graduate medical education system. We are particularly interested in these presentations.

The shortage of primary care physicians has been identified as one of our major health manpower problems. Over the past two decades an impressive number of public and private commissions and committees have recommended that we should increase the number of new physicians trained in the primary care specialties.

Improvements in availability, quality, and cost of health care services have all been associated with a larger supply of primary care physicians. This morning we will be seeking the answers to four questions: What constitutes primary care? How much of all of the physician services needed by a community can be provided by primary care physicians? What kind of training is necessary to provide high quality primary care? How can health manpower legislation contribute to an improvement in the mix of specialists being trained?

Our witnesses come from all regions of the country and are well qualified to discuss these important issues with the committee. Following our consideration of primary care, we will hear from representatives of the major universities and schools of veterinary medicine, podiatry, optometry, and then the pharmacy.

Other witnesses today include experts in the fields of public health and health administration and representatives of a number of associations and organizations important in the health care field.

This is our third day of hearings on the health manpower bill. These hearings will continue Wednesday afternoon and conclude on Thursday.

Our first witness this morning is Dr. Harvey Estes. Dr. Estes is chairman of the Department of Community Medicine at Duke University and was chairman of the steering committee for the Institute of Medicine study of primary care.

Dr. Estes, we are pleased to have you with us.

We have a copy of the text of your statement and we will put it in the record in its entirety.

What I would like to ask you to do is summarize your statement in no more than 5 minutes.

STATEMENT OF E. HARVEY ESTES, JR., M.D., CHAIRMAN, DEPARTMENT OF COMMUNITY AND FAMILY MEDICINE, DUKE UNIVERSITY

Dr. Estes. Thank you.

Mr. Chairman, I appreciate the chance to be here. In 1976 and 1977, a committee of the Institute of Medicine studied various aspects of primary care, including such questions as who should provide it, how many are needed, how can more medical students be attracted into primary care, et cetera.

The first task of the committee rested on the question of definition of primary care. For many years we have spoken of primary care in three categories: first primary, then secondary, then tertiary care. Primary care has been defined as the first level of care, that which is traditionally provided by a family practioner, a general internist or a general pediatrician, usually office-based.

Secondary care is defined as that type of referral or specialty services usually found in community hospitals, such as the care provided by orthopedic surgeons, ophthalmologists, urologists and so forth.

Tertiary care was defined as that type of specialty services usually found only in complex medical centers, open heart surgery, special cancer treatment and so forth. On the surface these definitions are simple and straightforward, and yet they are not because of variations in the interpretation of the term "primary care," some defining it as outpatient rather than inpatient services, some defining it as first contact services and others defining it as that given by a particular specialty such as family doctors.

The IOM's committee quickly concluded that these definitions were not sufficient. We were more interested in such questions as what should primary care be like.

My statement, then, is a summary of these conclusions. Our conclusion was that primary care was not a set of training but was an array or set of services usually provided by a doctor and a team of other individuals in a variety of locations, including homes, nursing homes, offices, hospitals and so forth.

We arrived at a set of adjectives and a set of descriptions and also a checklist which can be used by an office or clinic to test whether or not this office or clinic is giving primary care of this admittedly exemplary type. I have provided for you a reprint of that chapter of the report.

The first adjective describing good primary care is "accessible." Patients should be able to reach their doctor or member of the team at all times. In addition, the location of the services should be such that patients can reach them, and the facility should be comfortable and pleasant.

The second adjective was "comprehensive." By this we meant that the great majority of problems presented by patients coming into the door of this particular unit should be able to be handled by the primary team. The services might range from general preventative exams to handling minor trauma, and would certainly include preventative care and counseling.

The rest of the problems are, of course, referred to the appropriate level of secondary and tertiary care.

The third adjective is "coordinated." The primary care doctor should be a manager of his patients' problems, providing information to specialists, receiving information back from specialists, and interpreting this to the patient. He should answer for the patient those questions about choice of treatment, life habits and so forth which all patients have.

The fourth adjective that we chose is "continuous." Primary care should provide continuity over time. Even if the patient is referred, the doctor should seek out the records of the referral and incorporate this into his own knowledge base and into the patient's record for future use. Unnecessary referral to an emergency room or other providers would destroy this type of continuity.

The fifth and last adjective chosen was the adjective "accountable." Primary care should take the lead in examining its own practices and care, should be honest and forthright with the patient and should otherwise make the patient a partner in the process.

Why is all of this important? We felt that it was important because primary care is care which people themselves desire and seek, because primary care is the backbone of any rational system of distribution of health and medical care, because primary care is cost effective, much more so than care delivered by a series of referral specialists not connected with one another in any organized system.

At one time in our history, almost all doctors were primary care doctors. However, in response to the explosion of medical knowledge following World War II, there was a corresponding explosion of numbers of specialists. In fact, most medical schools stopped training general practitioners, and pediatrics and internal medicine moved in the direction of subspecialization.

Those general physicians who were in place at the beginning of this trend were slowly diluted out by the output of specialists. In addition, these new specialists were congregating around hospitals. The end result was the geographic and specialty maldistribution of which you are all aware.

In examining the reasons for students' preferences for specialties, there were some facts which we felt deserved attention. Among these were economic considerations and among these were medical school considerations. These are contained in the summary, Mr. Chairman.

One of the ones I would like to underline is the economic disadvantages which we felt were key. I hope that will come out further in the discussion.

Thank you.

[Dr. Estes' prepared statement follows:]

WHAT IS PRIMARY CARE?

(Statement by E. Harvey Estes, Jr., M.D., Chairman, Department of Community and Family Medicine, Duke University, March 24, 1980)

In 1976 and 1977, a Committee of the Institute of Medicine studied various aspects of Primary Care, including such questions as "Who should provide it?", "How many are needed?", "How can more medical students be attracted into primary care?", etc. The first task of the Committee was to agree on a definition.

For many years, medical care has been divided into categories - primary, secondary and tertiary care. Primary care was defined as the first level of care, that traditionally provided by a family practitioner or a general internist, usually office based. Secondary care was defined as that type of referral or specialty medical services usually found in community hospitals - such as care provided by orthopedic surgeons, ophthalmologists, urologists, etc. Tertiary care was defined as that type of specialty services usually found only in complex medical centers - such as open heart surgery, special cancer treatments, etc.

On the surface, these definitions appear simple and straightforward, yet they are not. The problem was in the definition of primary care. Some defined it as care which is given on an outpatient rather than inpatient setting. Some defined it as first contact services. Still others defined it as care given by family doctors.

The IOM's multidisciplinary committee quickly concluded that these definitions were not enough. We were more interested in the question of "What should primary care be?". My statement is a summary of these conclusions.

Primary care is a set or an array of services, usually provided by a doctor and a team of other individuals, usually in a variety of locations, including home, office and hospital. We arrived at a set of adjectives and a set of descriptions of these services, and also a checklist which can be used by an office or a clinic to test whether or not it is giving primary care of this exemplary type.

The first adjective describing good primary care is accessible. Patients should be able to reach their doctor, or a member of the team, at all times. In addition the location of the services should be such that patients can reach them, and the facilities should be such that they are comfortable and pleasant.

The second adjective is comprehensive. The great majority (about 90%) of the problems presented by the patient should be handled by the primary care team. These services might range from general preventive exams to the handling of minor trauma. The rest of the problems are, of course, referred to an appropriate secondary or tertiary level of care.

The third adjective is coordinated. The primary care doctor should be a manager of the patient's medical and health problems, providing information to specialists, receiving information back from specialists and interpreting this to the patient. He should answer for the patient those questions about choice of treatment, life habits, etc. which all patients have.

The fourth adjective is *continuous*. Primary care should provide continuity over time. Even if a patient is referred, the doctor should seek out the results of the referral, and incorporate this information into the patient's record and into his/her own store of knowledge. Unnecessary referral to emergency rooms or other providers destroys continuity.

The fifth and last adjective is *accountable*. Primary care should take the lead in examining its own practices and care, should be honest and forthright with the patient, and should otherwise make the patient a partner in the process.

Why is all of this important? Because primary care is care which people value and desire. Because primary care is the backbone of a national system of distribution of health and medical care. Because primary care is cost effective, much more so than care delivered by a series of referral specialists.

At one time, almost all doctors were primary care doctors. However, in response to the explosion of medical knowledge following World War II, there was a corresponding explosion of numbers of specialists. In fact most medical schools stopped training general practitioners, and pediatric and internal medicine moved in the direction of subspecialization. Those general physicians who were in place at the beginning of this trend were slowly diluted out by the output of specialists. In addition, the new specialists were congregating about the hospitals, which provided them with the technical support they were trained to use in their practice.

The end result was the geographic and specialty maldistribution problem of the 1960's, of which you are all aware. You are also aware of the creation of a new "generalist" specialist, the family physician, and the rapid increase in numbers of students admitted into medical schools, all being responses to perceived needs of the public, caused by a shortage of primary care doctors.

The conclusions of the IOM Committee were that we did *not* need further increases in numbers of schools or medical school class size. The committee felt that we should continue to urge more students to enter primary care fields rather than referral specialties.

In examining the reasons for students' apparent preference for specialties, there were some facts which we felt deserved attention and correction. As a group, primary care doctors work more hours and are paid less than their specialist counterparts. In many locations specialists are paid a much higher fee than primary care doctors, even for doing the *same* work. For example an obstetrician might be paid twice as much as a family doctor for a normal delivery. The committee felt that this was wrong, and suggested that higher fees for specialists should only be paid when the higher skills of the specialist were *needed*, and certified as needed, by the primary care doctor.

In addition to this and other economic recommendations, the group felt that medical schools should choose students who are more likely to enter primary care and expose them to the exemplary type of primary care defined earlier, in order to make them aware of the rewards of this type practice.

In summary, primary care is the backbone of an effective, responsive, and coordinated health care system, and should receive the encouragement and support to ensure its survival.

Mr. **Waxman**. Thank you very much.

I would like to ask you what is primary care. Is it real? We all know what surgery or psychiatry are, but what is primary care? How would you define it?

Dr. **Estes**. It is a set of services. It is an attitude of a physician with respect to his patient. It is a willingness of a physician to be a manager for his patient. It is real. It can be trained for. It exists, a point which many have doubted.

Mr. Waxman. What is primary care training? Is primary care something one needs to be trained to provide, and how does training for primary care differ from training for other specialities?

Dr. **Estes**. In broad terms, I would include in my definition of primary care three types of training at the present moment: family practice or family medicine training; general internal medicine; general pediatrics.

These training programs differ from the usual training program in several important ways. One important way is in their setting. Their setting is primarily outpatient rather than inpatient. Not to deny that they do have inpatient experience, but the majority and central focus of their training is in the ambulatory setting.

The second is their training to be managers or omsbudsmen for patients, the ability to see the patient's problem in context, not as an illness but as a person with an illness, and to manage that patient's problem in the full context of his own person, his interaction with the family, his interaction with the workplace and his interaction with the community.

I would say the management aspects of primary care training are paramount. This is a part of training in these disciplines I have mentioned, and I think it is key to what constitutes primary care training.

Mr. **Waxman**. Do traditional internal medicine and pediatrics programs actually train physicians to provide primary care? What about surgery, dermatology or other specialties?

Dr. **Estes**. I was trained as an internist and I do still practice as an internist. My own feeling is that many internal medicine training programs, especially in the past, have not adequately trained for the job of primary care. They have trained superbly in the area of illness care, particularly in specialty areas.

But the management role, the ability to take the patient back into the home, his business, family and occupational context, and particularly the preventative aspects have not been well emphasized by many departments of internal medicine in the past.

That does not deny that some do, but it has not been an across-the-board thing.

You asked about dermatology and some other subspecialties. For the most part, they do not train for primary care; they train for their own particular subset of problems. They train well in those subsets but they do not train for this overall management role I mentioned.

Mr. **Waxman**. I believe your statement indicates that the percentages of all the services needed by a population that could be classed as primary care would be as high as 90 percent. Is that an accurate statement?

Dr. ESTES. Yes; this is a figure which, of course, is an opinion. The committee, which was a multidisciplinary committee, it felt that at least 90 percent of a patient's problems should be handled by a good primary care physician operating in his office setting.

I would guess, that, in most office contexts it is considerably higher than that. Probably most family physicians and most general internists would refer less than 10 percent, probably in the range of 3 to 5 percent.

Mr. WAXMAN. What percentage of our physicians currently in practice are in the primary care specialties?

Dr. ESTES. That is hard to pin down because it depends upon what definition you adopt. One would have to make some guesses. The guesses have ranged all of the way from 30 to 60 percent, I would guess, that the true figure lies within that range. My guess is that many who are now classified as primary care physicians in our rough classification scheme function more as subspecialists than generalists, and I would put it toward the lower end of that scale but that is a personal opinion.

Mr. WAXMAN. What percentage of our new physicians should be trained in the primary care area?

Dr. ESTES. Family practice has emerged on the scene as a strong force and is now accepting a significant percentage of the output of U.S. medical schools. It is still much too early for family medicine to have made an impact on national manpower statistics. In fact, I think in most statistics which relate to this area, general practice and family practice are lumped together. The total number may still be declining.

The number of older general practitioners who are retiring may be more rapid than the influx of new family practitioners entering the combined field. Certainly family practice will have an impact, and a major one, in years to come. It is small at this moment.

Mr. WAXMAN. The Institute of Medicine report suggests that we need in the range of 60 to 70 percent of the new physicians to be trained in the primary care area.

Dr. ESTES. Yes.

Mr. WAXMAN. Why don't we train more physicians in the primary care specialties? What are the factors in the system that lead us to train so many specialists, and how can we remedy that other than through a quid pro quo system.

Dr. ESTES. In the committee's viewpoint, there are, at the present time, economic disincentives and medical school disincentives. To look at the economic disincentives first, the figures show that the primary care physician works longer hours and is at the lower end of the payment scale for physicians. So they work longer and receive less payment.

There are disincentives in the system in many areas. For example, a specialist, an obstetrician-gynecologist, does a normal delivery. This individual may be paid twice what a family practitioner is paid for the same job.

Now, to be sure, if this is a complex, difficult delivery, it may require the additional services of a trained obstetrician, but in most cases this is not necessary. Yet, they are currently paid at different rates.

These financial disincentives are clearly there. and in the opinion of the committee, they are having an impact on the individuals' optional decision for entry into specialties.

There are other disincentives within medical school training. For the past 20 or 30 years, medical schools have not had models of good, solid primary care practitioners on their faculties. People who practice primarily in an outpatient setting, and who assume the management role which I have mentioned, have not been a part of the faculty the last 20 years.

It was our recommendation that good, solid primary care be in place in every medical school and that all medical students be exposed to this as a part of their training. In addition we felt that medical schools should make some effort to choose those individuals who would be philosophically more likely to think of the patient, and the illness in the context of the patient, rather than illness per se, with the patient as an incidental factor.

This is a tough thing to do, and we don't quite know how this selection can be made ahead of time, but we felt that there were emphases that could be considered in choosing students—that would select students with a more humanistic approach rather than a more scientific approach. Incidentially, we were not against science.

Mr. WAXMAN. Is it easier to finance specialty than primary care training programs?

Dr. ESTES. I beg your pardon?

Mr. WAXMAN. Is it easier to finance specialty rather than primary care programs?

Dr. ESTES. Much easier. Primary care training is outpatient based. Most of the funds used in operating hospitals are derived from inpatients. Therefore, the hospital is taking inpatient funds and applying them to the outpatient setting, which many of them are not inclined to do. Outpatient settings are not cost-effective from the hospital manager's standpoint.

In addition to that, the fees that are derived from patient care in primary care clinics are at the lower end of the payment scale. These are the $10 office visits rather than services at the high technology, very expensive end of the reimbursement spectrum. Therefore, they do not make enough from their own patient income to support their own operation.

It is necessary, in my opinion, to support them from external sources.

Mr. WAXMAN. What changes would you recommend for us on the reimbursement system?

Dr. ESTES. Well, this is a complex issue, as you are well aware. My own preference would be some system that would place the primary care physician at financial risk, first of all, and give him a gatekeeper responsibility with respect to funds flowing into the secondary and tertiary level.

I think this would order the system in a more logical way than it is now. It would use primary care where it is needed and would use secondary and tertiary care where it is needed. By placing the primary care physician at risk, it makes him a partner in this enterprise. I think for the most part they are willing to do that.

I think that this change would be the most fundamental thing that could be done to correct problems. Aside from this very drastic step, I think that the previously mentioned inequities in reimbursement could or should be obliterated. It is not logical that one physician gets paid twice or three times as much as another for the same task, especially when more expertise and skill is not needed.

I would not deny that the secondary and tertiary physician deserves extra pay for those skills when his skills are needed.

Mr. **Waxman**. Thank you.

Dr. Carter.

Mr. **Carter**. Thank you, Mr. Chairman.

I began practicing in 1940. At that time approximately 76 percent of all non-Federal physicians involved in primary care were family practitioners or general practitioners, according to one of the charts provided for today's testimony. Since that time, the percentage has steadily declined to a low of 16.3 percent in 1978.

Recently, as a result of Federal assistance, there has been a significant growth in the number of residency training programs in family practice. However, the historical decline has been significant. How do you account for this great diminution in the number of family physicians or primary care physicians?

Dr. **Estes**. Dr. Carter, our medical schools simply stopped training them about 1950 or so and there were no general practitioners trained from about that point. Well, I shouldn't say none, but relatively few until family practice came into the picture as a new discipline in the late 1960's.

Mr. **Carter**. As a new discipline?

Dr. **Estes**. Yes, a new discipline in a formal sense.

Mr. **Carter**. We had always had it but it was just given a little more emphasis.

Dr. **Estes**. I do think the Federal support for family practice has been key in starting new programs. As you know, there are now 400-odd training programs and these are accepting a significant number of graduates of new medical schools, an increasing number each year.

I think young people are interested in this discipline. They are moving into it. I think the Federal support has been key in wresting from the medical schools a place in the Sun, if you will. I think it has been effective.

Mr. **Carter**. What disciplines do you consider part of the training of a family or primary care physician?

Dr. **Estes**. Family medicine includes training in medicine, pediatrics, obstetrics, gynecology, surgery, orthopedics, dermatology, E. & T. But overlying all of that is this management function, this problem-solving function that places the patient back as the center of care. I think that can't be removed from it.

Mr. **Carter**. I feel the management function does have a place, but I believe the training should be excellent in all those areas which you mentioned. Do you recommend for instance, that a primary care physician takes care of a fracture?

Dr. **Estes**. Sure.

Mr. **Carter**. Do you think a family practitioner should handle deliveries?

Dr. **Estes**. Yes, sir.

Mr. **Carter**. What percentage of deliveries are normal and would occur normally without the assistance of a physician or anyone else?

Dr. **Estes**. You are in a better position to answer that than I, Dr. Carter, and it depends upon whether you are using fetal monitoring and a few other things, I guess, but certainly the vast majority are normal deliveries.

Mr. **Carter**. Ninety-five percent of women would get along all right, 95 to 96 percent. Approximately 4 percent of the deliveries lead to difficulties. You can look that up anywhere you want to, but that is the way it is. That many would get along even without the presence of a physician, a nurse or anyone else.

So a primary care physician could very easily do this, but he should have training in this, well-grounded training in all of these disciplines, which you mentioned. Of course, you mentioned dermatology, which I think is very necessary, too.

If you have a circinate copper-colored rash on his body, what would you take it to be, if it were accompanied by mucous patches in the mouth and other places?

Dr. **Estes**. I think you would have to consider lues.

Mr. **Carter**. I think it would be lues, would it not?

Dr. **Estes**. Yes.

Mr. **Carter**. That is something I was taught and learned years ago. I think a physician must be grounded in all of these disciplines, every one of them.

Do you encourage medical training in remote and underserved areas?

Dr. **Estes**. Yes, sir. It is a part of training in our training program. And I think it is important to expose young medical students to what goes on in the hinterlands as well as the tertiary medical centers.

Mr. **Carter**. Yes, sir. What would you advise one of these residents out in a remote AHEC area who has an arm presenting in an obstetrical case?

Dr. **Estes**. Dr. Carter, I am an internist, not an obstetrician, but I would get help quick.

Mr. **Carter**. You wouldn't shake hands with the baby.

Dr. **Estes**. No, sir.

Mr. **Carter**. That is one of the old answers, as it happens.

I certainly support an increased number of primary care physicians, but I also support the best of training in all of these disciplines. I think it is wise for these young physicians to practice in a remote area some of the time. Perhaps they might like the area and decide to stay. However, they much receive thorough training with excellent physicians in charge who can help them.

If they are not properly trained, this mere presence in an isolated area wouldn't do much good, would it?

Dr. **Estes**. No.

Mr. **Carter**. It might present them with very serious problems such as a singling breech or an arm presentation or something of that nature, which many private primary care physicians must learn to take care of if it is possible, even in remote areas.

Most of them, I am sure, would rather refer those patients and would if they could. However, sometimes they don't have that opportunity. How extensive should their surgical training be, do you think?

Dr. **Estes**. I can tell you our opinion in our own training program. We train the family physician to do office surgery but not to do operating room surgery. We do not train them to do hernias and appendectomies, except as assistants, but that varies from place to place. West Coast training programs generally train their family physicians to do such procedures, because they practice in more isolated areas.

Mr. **Carter**. Well, people are not as isolated as they were once. Hill-Burton hospitals appear all over our country. At a Hill-Burton hospital if you had a lady come in with a blood pressure of zero and a ruptured uterus with the fetus in the abdomen, what would you do?

Dr. **Estes**. If I were a primary care physician, there would be nothing else to do but to proceed, with surgery because there would be no chance for the patient otherwise.

Mr. **Carter**. What would your procedure be?

Dr. **Estes**. Again, you are pushing me in areas in which I am not expert. I would guess this would be a hysterectomy.

Mr. **Carter**. Yes, and it is very difficult to do. I have been faced with such a problem. Unfortunately, the fetus, as it generally happens with a ruptured uterus, was already dead. But after doing the hysterectomy, although it is almost impossible with a large uterus like that to do a complete hysterectomy, you can do a vaginal cut, a cut around the uterus to stop the bleeding.

In this case, the patient lived for 5 years until she was shot by her husband.

Thank you very kindly.

Mr. **Waxman**. Thank you very much, Dr. Carter.

Dr. Estes, we appreciate your being with us and giving us the benefit of your views on this legislation. We look forward to working with you.

Dr. **Estes**. Thank you.

Mr. **Waxman**. Our next witness is Dr. Alvin Tarlov, the chairman of the Department of Internal Medicine at the University of Chicago. Dr. Tarlov is currently the chairman of the Graduate Medical Education National Advisory Committee and is here to discuss the work of that committee.

Dr. Tarlov, if you would begin by summarizing your statement. We have your complete statement, which we will make a part of the record.

Mr. **Carter**. Do you know Dr. Beatrice Tucker or Dr. Harry Benaaron?

Dr. **Tarlov**. No, I do not.

Mr. **Carter**. Did you know Dr. J. B. DeLee?

Dr. **Tarlov**. Yes, I did.

Mr. **Carter**. He wrote a rather good textbook on obstetrics. Dr. Tucker and Dr. Benaaron ran the Chicago Maternity Center, which is now defunct, I understand.

Dr. **Tarlov**. That is correct.

Mr. **Carter**. It was my pleasure to do my obstetrical work at Dr. DeLee's clinic down in that portion of Chicago, which is considered a little bit rough at the present time. Under their direction I was able to deliver youngsters in homes all over the city of Chicago.

Dr. Benaaron, I think, is deceased. Dr. Tucker is still living and Dr. DeLee has already gone, of course.

Thank you, Mr. Chairman.

Mr. WAXMAN. If you would summarize your statement for us.

STATEMENT OF ALVIN R. TARLOV, M.D., CHAIRMAN, GRADUATE MEDICAL EDUCATION NATIONAL ADVISORY COMMITTEE (HEW)

Dr. TARLOV. Thank you very much.

I would like to identify at the very start that I am trained as an internist. I practice and teach general internal medicine. I have been involved for the last 7 or 8 years now in conducting manpower-type studies in the field of internal medicine and have been chairman of the Graduate Medical Education and National Advisory Committee for approximately 20 months.

Directing your attention specifically to GMENAC, I would like to emphasize that in my opinion, there are three significant outcomes from the GMENAC which should receive earnest attention at the present time.

First, the committee and its staff in the Office of Graduate Medical Education have developed specific manpower methodologies. These methodologies represent the most sophisticated and comprehensive approach to health manpower planning, yet developed. I believe these methodologies promise to become the foundation for manpower planning and public policy development in the future.

These methodologies and their application by GMENAC represent significant breakthroughs in health manpower planning. The science of manpower assessment has been advanced by the application of these methodologies. We have developed confidence that the model for projecting the supply of physicians into the future and the model for determinining the requirements for health services in the future have become subject to precise quantitative approaches.

To be sure, these methods, like all new methodologies in science, are in early stages of application. Undoubtedly, they need to be refined, made more sophisticated. They need to be made more efficient. They need to be validated against long-term actuality.

Nonetheless, in my view, health manpower policy can be substantially more rationalized now than it could before these methodologies were developed by GMENAC. Second, the data base on illness, health, physician supply and the factors which impact upon these considerations have been collected, assembled and analyzed, and they represent a data bank the comprehensiveness of which has never before been accomplished.

This data bank forms the foundation for the methodologies I referred to before. This data bank is massive in scope. It needs to be further classified, further studied, further added to. But it represents an invaluable national resource and it needs continuing attention long into the future.

Third, GMENAC has resulted directly in an extraordinary collaborative effort between the Federal Government and the private health sector. Never before in health planning, to my knowledge, has such a partnership on as broad a base been forged.

Further, the collaboration is working and it is effective. Dozens of national professional organizations and literally dozens of national leaders in the health area have directed their attention and their energies and their assistance to this task.

At the same time, administrative and financial support and the technical data collection, assembly and analysis have been conducted by the GMENAC staff and the Health Resources Administration. This collaboration must be captured for the future, not only because it is effective in health manpower planning, but also because it demonstrates a governmental private process which would win almost everyone's admiration.

For the above reasons, I believe strongly that the GMENAC operation ought to continue; that the committee members ought to continue their work uninterruptedly; that the staff must be retained for this important function; and that a long-term GMENAC-like activity should be planned for.

My personal knowledge of governmental operations and a limited scope of my appreciation for all of the considerations which go into the kinds of decisions you are making do not permit me to make an informed judgment as to whether GMENAC should be authorized by law.

Nevertheless, I hold a strong conviction that the GMENAC operation should continue uninterruptedly into the indefinite future. Now, the GMENAC data and recommendations will not be completed until over the summer months, and the final report will be prepared and submitted in September.

I would, however, like to caution on the question of oversupply or undersupply. In the aggregate, I am not sure at the present time whether it would be wise for the Nation to assume that there is an oversupply or even an undersupply. I am not sure, for example, that there is going to be in 1990 an undersupply in the primary care area.

I would caution about the question of 90-percent primary care services being provided or all health services being provided by primary care physicians. We know that is an oversimplification. We know, for example, that the surgical services, the radiologic services, the services by pathologists far exceed 10 percent, and probably even if all Americans had a primary care physician, the numbers of primary care physicians needed for that task probably would not exceed 50 percent of the aggregate requirements for supply of physicians.

I would also be cautious about the additions to the supply that you or we might project for 1990 or the year 2000. There are some factors, for example, what the States are doing in manpower and the expansion of the State medical schools, that appear to be continuing uninterruptedly.

The question of the foreign medical graduates is a large one with the entry of 2,000 a year, apparently, without our ability to stem that influx. The rising number of U.S. citizens studying in off-shore medical schools, I think, forecasts an importation from those sources of many thousands per year.

I would simply wish that the committee exercise some caution in jumping to some conclusions about subjects which are just now coming to the surface and being analyzed.

I would be prepared to respond to questions you have.

Mr. **Waxman**. Thank you very much for your testimony.

If you are correct about the uncertainty of the future, for which we ought not to overact now, it seems to me that is a very good argument for continuing GMENAC in existence.

Dr. **Tarlov**. I believe that. I would support that. It is unfortunate you are in a position of having to make some very large decisions right now. I think the most dependable source of information on this subject is now beginning to fall in place and be integrated.

Mr. **Waxman**. Let me ask you some questions about GMENAC for the record.

Dr. **Tarlov**. Yes?

Mr. **Waxman**. Could you summarize for us the types of people who have been involved with GMENAC? Are most of them physicians? And what about people who have been involved with the AMA or the medical schools?

Dr. **Tarlov**. All right. There are two major inputs from the private sector into GMENAC. One is the committee members themselves. The committee is composed of 22 individuals. I think 14 are physicians. Of these physicians, some are internists, family physicians, pediatricians, an orthopedic surgeon, ophthalmologists selected with considerations of geography and other considerations, as well. There is a urologic surgeon there also.

The other members of the committee are two nurses, a representative from one of the insurance companies that has a large stake in underwriting health insurance, an economist, three representatives from the Federal Government—one from the DOD, one from the Veterans Administration, and Dr. Henry Foley, the Administrator of HRA.

Then there is the participation of a great number of professionals in the methodology itself, in the so-called Delphi process, and I think that process has touched almost every professional organization and its leadership in the United States, extending all of the way, I think, from the leadership of the major medical organizations, the American Medical Association, the American Osteopathic Association.

It includes the various professional medical societies as well as the American Nursing Association, the Association of Clinical Psychologists, the American Nurse Midwifery Association, et cetera. These individuals have all participated in the deliberations relevant to their particular field. It is an extraordinary collaborative effort which has successfully brought to bear on these issues input from the profession in a very meaningful way with the Federal Government in their support for this project.

Mr. **Waxman**. What generally has GMENAC decided about the need for new physicians? Are we training enough primary care physicians? What about psychiatrists?

Dr. **Tarlov**. It is a little bit too early, a few months too early for me to comment on that question for GMENAC. Speaking as an individual and looking at the data and working with it myself, if there is an imbalance in the aggregate, it is not going to be a large one for 1990.

Now, what happens in the decade between 1990 and 2000 may be very serious, and largely because of the continued expansion of the number of first-year entrants to medical school in the United States beyond the 17,000 where we are at the present time, and also what appears to me to be a large number of American citizens in the off-shore medical schools, almost all of whom will come back.

At a time when we are graduating 16,000 or 17,000, to envision another third or so again of that number, coming into practice in the U.S., either from off-shore schools or graduates of foreign medical schools elsewhere, seems to me to represent a national problem.

Now, in regard to the primary care specialties, say in 1990 there may be 240 million Americans. A primary care physician can care for, I think, comfortably somewhere in the neighborhood of 800 to 1,100 people in a comprehensive way. Now, that translates, then, into a primary care requirement of maybe 250,000 primary care physicians if one takes that simplistic approach to the matter.

I would not project a serious shortage in 1990. Now, that is a personal view. That has not come out of GMENAC. That comes from my synthesis, what I think the data shows up to this time.

I would be cautious about it. I am not sure there is going to be a shortage.

Mr. **Waxman**. As to the lack of shortage you see in the next decade, how is that related to the numbers of physicians in various graduate medical school training programs? Are we meeting those needs for the next decade by our training programs?

Dr. **Tarlov**. In the aggregate I think that we are, but I believe we are going to find that there are still some areas that need a lot of attention. My view is at this time that the attention given to primary care should continue, not an increased number necessarily, but the programs have to be supported and their facilities enriched, and especially their teaching capabilities have to be improved, their academic horizons enriched and made more stable, and careers as academic family physician teachers, academic teachers of general internal medicine and general pediatric medicine have to be continued and supported.

The numbers, however, I think we are going to find are nearly correct as they are coming out now to meet the national requirements. However, there are some other fields in which, even at this early stage, they appear to me to be beset by shortfalls that are serious.

These are in psychiatry, in physical medicine, in preventive medicine and in anesthesiology. I would think that efforts to amplify the numbers ought to be directed there. I would be cautious about amplifying further the numbers in primary care training.

Mr. **Waxman**. Do you think there is a shortage in primary care now?

Dr. **Tarlov**. Yes.

Mr. **Waxman**. What do you see happening in the next decade that will change that? Do you think there will just be a natural trend in the graduate medical school education programs for primary care?

Dr. **Tarlov**. That may occur also, but I think the fruits of the efforts of the last decade will be adding to the primary care resources in practice.

Mr. **Waxman**. Even though we have heard all of the disincentives there are in the system for people to go into primary care? Without any changes in those disincentives, why would you expect that there would be more people going into primary care?

Dr. **Tarlov**. First of all, I would say that the shortage which was perceived in the 1970's is indeed real. But the growth of the medical graduates from something in the neighborhood of 7,000 or 8,000 in the late 1960's to 16,000 now, with an increase in the numbers going into primary care, will lead to a doubling of primary care physicians from the early 1970's to 1990 without any equivalent increase in the population.

So I think that that momentum that was developed within the training programs in the 1970's will carry toward an adequate supply in the 1990's. Now, it might be there needs to be some fine tuning, a 10 to 15 percent increase or decrease, something of that sort. But it is going to be pretty close to the target, I think, in my opinion.

Mr. **Waxman**. The administration is proposing to phase GMENAC out in September. Do you think GMENAC can finish its report by September?

Dr. **Tarlov**. Yes.

Mr. **Waxman**. What about the September report? Do you think it will be the last word in the study of specialty distribution and that no additional study will be necessary?

Dr. **Tarlov**. No, I don't. I think that the process, the methodologies that have been devised ought to be looked upon with really penetrating critical analysis. The recommendation, the data itself will not be accepted by all quarters. It needs further study. It needs debate, acceptance by the Government, acceptance by the private sector, acceptance by the consumers.

I think the methodolgy itself needs to be refined. I think if GMENAC went out of business on September 30, the national resource in terms of the methodology and the data bank would lie fallow. I personally feel that that would be detrimental to health planning and policy development.

Mr. **Waxman**. Who will implement any changes that might be recommended by GMENAC?

Dr. **Tarlov**. I think that there are a number of areas. One would have to be the numbers themselves, the numbers of physicians and their specialty distribution. The other has to do with factors which impact on specialty choice, geographic distribution and the kinds of services provided.

In regard to the numbers, I believe that the fine tuning that will be necessary in the majority of specialties probably can occur within the profession and within the training programs and by making the information widely visible, encouraging discussion and debate on the subject and allowing natural forces to act on the training program directors and the individual specialties.

There will be other fields, however, in which I think the tuning is not so fine but it is large. In those particular fields, I feel that some added incentive and attention to resource development needs to be developed. And in those fields, I feel there is a real role for Government, both Federal and State, in helping achieve national objectives if there develops a consensus on that subject.

There are other areas, however, particularly the reimbursement one and the support for medical education itself which worry me a great deal. Those, I think, require some governmental action and consideration. I think that the reimbursement system, particularly the scale, is not something, of course, that the private sector can modify, and I would not attribute to it the major or central cause of specialty and geographic distribution.

But I do think it plays a role, and I do think there is a good deal of national attention focused on it at the present time. I do think that within the profession there is an acknowledgment that the reimbursment system needs a lot of attention and a good deal of modification.

Mr. **Waxman**. What do you see the relationship of GMENAC with CCME or other private organizations such as AMA and AAMC to be in the future?

Dr. **Tarlov**. I think we should follow the lesson we have learned or observed in the last 3 years. I think, in the vernacular, we have something very good going here. That is to say, we have a true collaborative, intimate relationship between the private sector and the Government. I think that that ought to be continued and brought in in a more meaningful way through the other organizations and the CCME, in particular.

I was pleased to see in this bill we are discussing that a formal representation from the Coordinating Council on Medical Education was written into that part of the bill which deals with GMENAC. I think that is a good idea.

I think that it perhaps was a mistake in the appointment process not to include on the original committee representation from the Association of American Medical Colleges, but I would not be too tough on that because, after all, there is not also a formal representation from other physicians organizations, the National Medical Association, for example, or the American Nurses Association.

So there were some oversights. But my own opinion is that these organizations have had ample opportunity to input into the deliberations.

Mr. **Waxman**. Thank you very much.

Dr. Carter.

Mr. **Carter**. Doctor, the preliminary report of your advisory committee suggests that primary care is an evolving concept of health organization and delivery in this country. Do you think that this concept will or should evolve to include fields of emergency medicine or obstetrics-gynecology?

Dr. **Tarlov**. I have ambivalence about that, to be sure. I will be up front with it. Taking obstetrics-gynecology first, I think that from the point of view of access, there is every reason to wish that obstetrics and gynecology would assume a primary care role. After all, they and family practice are major providers of care to a large segment of the population of females in the childbearing age.

Yet, I feel that at the present time, if one studies what an obstetrician-gynecologist does, there is no way, I think, that rational people could conclude that the obstetrician is providing primary care or general services for that population.

So I would say that it would be beneficial to be health care system if the obstetrician-gynecologists became trained and, in fact, delivered primary care services. But I don't see that happening in their training programs, and I think that that particular specialty soon ought to make a decision as to what its posture in the future is going to be.

Now, with regard to emergency services I believe that the system is not well served by the emergency physicians providing primary care. I think emergency physicians at the present time do provide some primary care, particularly in those areas where the patients do not have a general physician or in areas where the patient population for other reasons is not well covered medically.

But I think that we ought to move as a Nation toward the concept of Americans having a general physician, and you may call it a primary care physician, a generalist or whatever, for all Americans. I think that the emergency physicians are subsuming part of that role at the present time.

We ought to be grateful that they are, but I don't think that is the way to plan for the future.

Mr. **CARTER**. Well, putting it in a different way, do you think the training of primary care physicians should include training in emergency care and also obstetrics-gynecology?

Dr. **TARLOV**. Those are two questions, I believe, that the primary care physicians, yes, ought to be trained to care for most emergencies. That does not mean there is not a role for the emergency physician.

Mr. **CARTER**. Absolutely not.

Dr. **TARLOV**. There is, but I do believe primary care physicians ought to be trained to handle most emergency situations with their patients, and I think their practice ought to accommodate to the fact that those emergency situations can arise at any time in a 24-hour cycle.

Now, with regard to the provision of obstetrical care by primary care physicians, at the present time the only group of primary care physicians, I believe, training for that are the family physicians. And I think that that must and should continue. I think it is part of the philosophy of providing family care.

That makes it a requirement, more or less, for family physicians to deliver the children in that family; but I don't think that the general internist and the general pediatrician, at least in the next 25 years, wish to or will become trained to deliver babies.

Mr. **CARTER**. State that again, please, sir.

Dr. **TARLOV**. I think as far as we can see ahead, say 25 years, the general internist and the general pediatrician will not be trained to deliver babies. Now, an increasing proportion——

Mr. **CARTER**. But that has been part of medical education over the years before one specializes, though, has it not?

Dr. **TARLOV**. That is correct. Now, an increasing number of deliveries will, however, be handled by the nurse-midwife. At the present time there are 3.5 million deliveries a year. About 35,000, or 1 percent, are delivered by nurse-midwives. That fraction and number is likely to grow over the course of the next decade or two.

Mr. CARTER. Do you anticipate that GMENAC will recommend changes in reimbursement policies that would affect provision of services by primary care residents or primary care practitioners?

Dr. TARLOV. Do I expect it, or would I suggest it?

Mr. CARTER. Do you recommend it?

Dr. TARLOV. Yes, yes, oh yes. The answer is yes.

Mr. CARTER. In what way?

Dr. TARLOV. Are we talking, Doctor, about reimbursement of residents or the reimbursement of the practicing physician?

Mr. CARTER. Primary care residents or practitioners, both.

Dr. TARLOV. Well, let's take the resident question first. I believe that ambulatory care services conducted in a teaching setting ought to be reimbursed, ought to be reimbursable. I think the kind of patient revenues which now support inpatient care ought to be applied to ambulatory care as well.

Now, whether the residents themselves ought to be reimbursed for services in an ambulatory care setting is another question, and I am somewhat skeptical about the wisdom of directly reimbursing residents for services which they should be providing in a teaching setting.

I would prefer to maintain residents in training in a role more as students and less in the role of providers.

Mr. CARTER. They are usually salaried anyway, so you would suggest this payment be made to the hospital.

Dr. TARLOV. To the institution or the department providing the services.

Mr. CARTER. I understand.

Dr. TARLOV. I would insist at the same time, however, that supervision and instruction of those residents be documented, looked upon, examined and approached in an honest way.

Mr. CARTER. I had hoped that that would be so, but I think, as you know and I know, many times the resident does the initial work and the real physician is not there or else arrives just in time to perform the delivery, in the case of obstetrical care.

Dr. TARLOV. Yes.

Mr. CARTER. How do the responsibilities of this new Office of Graduate Medical Education differ from the responsibilities and mandate of GMENAC?

Dr. TARLOV. The Office of Graduate Medical Education in the Health Resources Administration essentially provides the staff work for GMENAC. That is to say, it has other functions as well but its major effort is in data collection, assembly, analysis and staffing the GMENAC operation.

I would say that without that staff, the GMENAC operation would be similar to other health manpower studies. That is, it would be a collection of opinions and arguments and assertions. The difference here is that HRA or HEW has provided a magnificent staff with well-trained people who are experienced in quantitative science, who are collecting data for our consideration.

I think that the level of competence of that staff needs to be emphasized, and I think if GMENAC were not to continue, it is very likely that that staff would dissipate. And even a few months of discontinuation of the GMENAC operation would, I think, lead to a diffusion of personnel into other activities, which would require, then, several years to recoup and build the quality of that staff again.

Mr. **Carter**. I see. I think you are correct that GMENAC should continue until its task is completed. There is one other question I would like to ask. At the present time I believe we have in the neighborhood of 447,000 physicians in our country. It is projected that by 1990 we will have some 600,000. That is according to your preliminary report, I believe.

At the present time we have departed from the interest rate on student loans which we had. I believe it was 12 percent, something in that neighborhood. Now we are going to the idea of letting students borrow their money at going rates, which would probably be in the neighborhood of 17.5 percent.

Under the first figures, it would cost a student even more than $140,000 to pay for his medical education at an interest rate of 17.5 percent, assuming the student could obtain that loan. Do you think this would have an adverse effect on the number of students applying to medical school; and if so, would it possibly diminish the projection of 600,000 physicians in 1990?

Dr. **Tarlov**. First I would like to respond, Doctor, about the numbers themselves. Our best estimate, 1978-79, was 418,000 physicians, including all of those in training, M.D.'s and osteopaths.

Mr. **Carter**. Our projection was 447,800, I believe.

Dr. **Tarlov**. And for 1990, including the trainees at the present time, it is my best estimate—not the GMENAC Committee's because they haven't come down on this yet—but my best estimate, including residents in training, is 565,000.

Mr. **Carter**. That is a difference of 35,000 from GMENAC.

Dr. **Tarlov**. From the earlier projections, yes. But be that as it may, your question is a central one. I think there is no question the high cost of medical education is going to be a potent dissuasive force on young men and women wishing to study medicine, and it will lead to a certain imbalance in the applications in that those who wish to or are capable of withstanding those costs will apply in uninterrupted numbers; but a large fraction of American youth, I think, will decide that they are not able to bear those costs.

Mr. **Carter**. The banks might decide that they were unable to make the loans.

Dr. **Tarlov**. They might. They might. I think it represents a potential perversion of the mix of applicants to medical schools.

Mr. **Carter**. I agree with you. Now, in order to increase the number of primary care physicians, do you think we should subsidize the interest rates for them and let them continue to have their loan at 12 percent, something of this nature? Would you recommend doing that in order to increase the number of primary care physicians, in our country today?

Dr. **Tarlov**. I understand the question but I really just don't have an opinion. I don't know how to lick that problem. That sounds like a reasonable thing to do, but I am woefully inexperienced in that field and I just don't know.

A preference that I have, and really it is just a preference, would be to create an income potential for the primary care physicians that is more satisfactory and allow it to be paid off at that end.

I would say another thing. If I believed that we are headed to a great shortage of primary care physicians, I would think that that incentive would be powerful, the one you have just enunciated, and might be useful. But whether it would be wise to implement that or not, I just don't know.

Mr. **Carter**. By the way, how is Jay Berkelhamer getting along?

Dr. **Tarlov**. Jay is fine. He told me to say hello to you and to those folks back there, as well.

Mr. **Waxman**. Dr. Carter, thank you.

Dr. Tarlov, thank you for your testimony. You have been helpful and we will evaluate it as we consider the legislation.

Our next witnesses will appear as a panel. Representing the American Academy of Family Physicians is Dr. Ernest Chaney, the chairman of the AAFP Board of Directors. Dr. Chaney is a family practitioner in Belleville, Kans.

Representing the Society of Teachers of Family Medicine is Dr. Terry Kane, president of the society and director of the family medicine training program at Duke University.

Speaking for programs in primary internal medicine is Dr. Tom Delbanco, director of the primary internal medicine program at Beth Israel Hospital in Boston.

I would like to welcome all of you to the hearing today.

I would like to repeat and urge upon you that you summarize your statements, which will be made a part of the record in their entirety, and keep to 5 minutes.

Dr. Chaney, go right ahead.

STATEMENTS BY ERNIE CHANEY, M.D., CHAIRMAN, BOARD OF DIRECTORS, AMERICAN ACADEMY OF FAMILY PHYSICIANS; TERRY KANE, M.D., PRESIDENT, SOCIETY OF TEACHERS OF FAMILY MEDICINE; AND THOMAS L. DELBANCO, M.D., CHIEF, DIVISION OF GENERAL MEDICINE AND PRIMARY CARE, BETH ISRAEL HOSPITAL (BOSTON)

Dr. **Chaney**. Thank you. Mr. Waxman, Dr. Carter, I appreciate the opportunity to appear before you today to present the academy's recommendations on this important health manpower legislation.

Before starting, I would like to answer one of the questions you brought out at the opening, Mr. Chairman, and that is the definition of primary care. The term "primary care" has been in a transitional phase during the past few years, whereas its original meaning indicated it was a function of the first physician seeing a patient in any episode of illness.

The common usage by both Government and medicine has endowed it with connotations considerably broader. The academy defines primary care as a type of medical care delivered which emphasizes first contact care and assumes ongoing responsibility for the patient in both health maintenance and therapy of illness.

It is personal care involving a unique interaction and communication between a patient and physician. It is comprehensive in scope. It includes the overall coordination of the care of the patient's health problems, be they biological, behavioral or social.

The appropriate use of consultants and community resources is an important effect of primary care. During the last decade, family practice in this country has experienced tremendous growth with the assistance of generous Federal financial support, first provided by the Congress in 1972.

When the specialty of family practice was officially recognized 11 years ago, there were only 15 approved residency programs where medical school graduates could receive training in family medicine. As shown in the material which we have had in our written testimony, by July of 1979, 6,666 family practice residents had completed training and there were 364 residency programs with an enrollment of 6,530 new residents

Despite the progress, much remains to be done to accomplish the objective of providing enough first year resident positions to provide graduate training for 25 percent of medical school graduates. The academy's recommendation is that the Congress continue the authority for support of family practice in medical schools, section 880 of Public Law 94-484, and for the support of family practice residency programs and programs to train teachers of family medicine, section 786(A) of the same public law.

We are pleased to note that the legislation introduced by the chairman and several members of this subcommittee renews these authorities while increasing the amounts authorized. We believe the figures we have provided can conclusively demonstrate that this money is accomplishing the objective of increasing the number of family physicians being trained in this country.

We are optimistic an increase in authorizations will work to assure we not only increase actual numbers but relative percentage of family physicians as well. I would like to suggest the subcommittee give consideration to combining the current section 780 and 786 authorities in a single authority as is done in Senate bill 2375.

It has been our experience that maintaining two separate authorities has led to confusion in the appropriation process. While we do not recommend changing the substance of the two authorities, we believe combining them would prevent this confusion.

In regard to maintaining the current language, I cannot overemphasize the fact that we believe the current program has been extremely productive, and to modify it would be a mistake. One piece of health manpower legislation introduced in the Senate, Senate bill 2144, provides that as a condition for receipt of grant funds, residency programs must be affiliated with a medical school.

Some of the best family practice residency programs are in community hospitals not affiliated with medical schools, and the academy is strongly opposed to this provision.

Before discussing other aspects of pending health manpower legislation, I would like to mention one other provision in H.R. 6802 of particular interest to the academy in its efforts to promote and strengthen residency training programs. This provision would amend title XVIII of the Social Security Act to provide that residents who are licensed to practice and who are training in general internal medicine, general pediatrics or family medicine may bill on a reasonable charge basis for those outpatient services provided in a primary training center.

Based upon discussions with family practice residency program directors, it is our understanding that current medicare law creates a significant difficulty for such programs. Under present law, medical residents cannot bill medicare patients for services rendered, and salaries for such residents are included in part of the hospital's reasonable costs. This rule does not apply if services are provided off provider premises, in which case services provided by residents are reimbursed on a reasonable charge basis.

While we are not aware that this has created problems on the inpatient setting or on inpatient-based residency programs, it has caused difficulties fo family practice residency programs.

The heart of this type of residency training is the model family practice unit, which is modeled after the physician's office and provides outpatient services in the same way they would be provided by a physician in private practice. Essential to this training program is the concept that the family practice resident functions as a personal physician for a defined group of patients.

Because they are residents, they cannot bill as would a personal physician; but because they are functioning as a personal physician, the teaching physician cannot meet the criterion of an attending physician and bill for those services provided by residents under his supervision.

We believe the medicare amendment proposed in H.R. 6802 would correct this current problem, and at the same time we are concerned that it not result in creating a situation whereby medicare would pay both reasonable charges and reasonable costs for the same services.

Accordingly, we hope, if this becomes law, steps would be taken in its implementation to assure that double billing does not occur, including promulgation of the requirement that if hospitals elect to adopt this system for services provided in a primary care center, no part of the salaries paid the residents or teaching physicians for time spent in the center would be included in the hospital's reimbursable costs.

We believe that GMENAC is a potent force in health manpower legislation and do support statutorily continuing with GMENAC. We would also consider statutorily defining its composition to insure representation by family physicians.

Thank you, sir.

[Testimony resumes on p. 361.]

[Dr. Chaney's prepared statement and attachments follow:]

STATEMENT OF THE
AMERICAN ACADEMY OF FAMILY PHYSICIANS
BEFORE THE
INTERSTATE AND FOREIGN COMMERCE
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT

MARCH 24, 1980

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE, I AM ERNIE CHANEY, A PRACTICING FAMILY PHYSICIAN FROM BELLEVILLE, KANSAS. I CURRENTLY SERVE AS CHAIRMAN OF THE BOARD OF DIRECTORS OF THE 47,000-MEMBER AMERICAN ACADEMY OF FAMILY PHYSICIANS. I AM PLEASED TO HAVE THE OPPORTUNITY TO APPEAR BEFORE YOU TODAY TO PRESENT THE ACADEMY'S RECOMMENDATIONS ON THE VERY IMPORTANT HEALTH MANPOWER LEGISLATION WHICH YOU ARE CONSIDERING.

FAMILY PRACTICE TRAINING SUPPORT

DURING THE LAST DECADE, FAMILY PRACTICE IN THIS COUNTRY HAS EXPERIENCED TREMENDOUS GROWTH WITH THE ASSISTANCE OF GENEROUS FEDERAL FINANCIAL SUPPORT, FIRST PROVIDED BY THE CONGRESS IN 1972. WHEN THE SPECIALTY OF FAMILY PRACTICE WAS OFFICIALLY RECOGNIZED ELEVEN YEARS AGO, THERE WERE ONLY 15 APPROVED RESIDENCY PROGRAMS WHERE MEDICAL SCHOOL GRADUATES COULD RECEIVE TRAINING IN FAMILY MEDICINE. AS SHOWN IN THE MATERIAL WHICH IS APPENDED TO MY WRITTEN STATEMENT, AS ATTACHMENT A, BY JULY OF 1979, 6,666 FAMILY PRACTICE RESIDENTS HAD COMPLETED TRAINING AND THERE WERE 364 RESIDENCY PROGRAMS WITH AN ENROLLMENT OF 6,531 RESIDENTS.

NOT ONLY HAS THIS DRAMATIC INCREASE IN THE NUMBER OF RESIDENCY PROGRAMS HAD A PROFOUND EFFECT IN CORRECTING SPECIALTY MALDISTRIBUTION, IT ALSO HAS HAD AN EFFECT IN CORRECTING GEOGRAPHIC MALDISTRIBUTION. SURVEY DATA WE HAVE COLLECTED SINCE 1975 SHOWS THAT RESIDENCY PROGRAM GRADUATES ARE INDEED LOCATING THEIR PRACTICES IN RURAL AS WELL AS URBAN AREAS. AS SHOWN IN THE TABLES APPEARING IN ATTACHMENT B OF MY WRITTEN STATEMENT, OVER 50% OF THE 1978 GRADUATES ENTERED PRACTICE IN COMMUNITIES WITH POPULATIONS OF LESS THAN 25,000 AND IN 1979, 48.8% ENTERED PRACTICE IN COMMUNITIES OF 25,000 OR LESS. EVEN MORE ILLUMINATING THAN THESE FIGURES ARE FIGURES GATHERED FROM A SURVEY OF ALL FAMILY PRACTICE RESIDENCY GRADUATES BETWEEN 1970-1978. ALTHOUGH THIS SURVEY HAS NOT BEEN FINALIZED, PRELIMINARY DATA OBTAINED FROM THE 3,733 RESIDENCY GRADUATES RETURNING THE SURVEY INDICATES THAT 53.1% ARE PRACTICING IN A COUNTY WHICH HAS BEEN PARTLY OR WHOLLY DESIGNATED AS A HEALTH MANPOWER SHORTAGE AREA.

DESPITE THE PROGRESS WHICH HAS BEEN MADE, MUCH REMAINS TO BE DONE TO ACCOMPLISH THE OBJECTIVE OF ESTABLISHING ENOUGH FIRST-YEAR RESIDENCY POSITIONS TO PROVIDE GRADUATE TRAINING FOR 25% OF MEDICAL SCHOOL GRADUATES. AS SHOWN IN ATTACHMENT C, 83% OF ALL NONFEDERAL PHYSICIANS INVOLVED IN PATIENT CARE IN 1931 WERE FAMILY PHYSICIANS/ GENERAL PRACTITIONERS AND THIS PERCENTAGE HAS STEADILY DECLINED TO A LOW OF 16.3% IN 1978. THE PHYSICIAN POPULATION IDENTIFYING ITSELF AS BEING IN FAMILY OR GENERAL PRACTICE IS OLDER IN AGE THAN THE AVERAGE PHYSICIAN POPULATION. CONSEQUENTLY, A SOMEWHAT HIGHER ATTRITION RATE BY DEATH AND RETIREMENT MAY BE EXPECTED FROM THIS GROUP THAN FROM THE GENERAL PHYSICIAN POPULATION.

In 1979, there were enough first-year family practice residency positions to accommodate 15.9% of all U.S. medical school graduates and we estimate this figure will increase to 16.9% in 1980. To reach the 25% objective by 1987, for example, an additional 1,318 first year residency positions will have to be created. In 1979, approved residency programs had the capacity to accommodate 2,500 residents at the first-year level but received well over 3,000 applications. Thus, last year alone, family practice was unable to accommodate some 500 physicians who might have entered the specialty.

It is the Academy's recommendation that Congress continue the present authorities for support of family practice departments in medical schools (Section 780 of P.L. 94-484) and for the support of family practice residency programs and programs to train teachers of family medicine (Section 786(a) of P.L. 94-484). We are pleased to note that the legislation introduced by the chairman and several members of this subcommittee renews these authorities while increasing the amounts authorized. We believe the figures we have provided conclusively demonstrate that this money is accomplishing the objective of increasing the number of family physicians being trained in this country, and we are optimistic that an increase in authorizations will work to assure that we not only increase actual numbers but the relative percentage of family physicians as well.

I would like to suggest that the subcommittee give consideration to combining the current Sections 780 and 786 authorities in a single authority as has been done in S. 2375. It has been our

EXPERIENCE THAT MAINTAINING TWO SEPARATE AUTHORITIES HAS LED TO CONFUSION IN THE APPROPRIATIONS PROCESS AND WHILE WE DO NOT RECOMMEND CHANGING THE SUBSTANCE OF THE TWO AUTHORITIES, WE BELIEVE COMBINING THEM WOULD PREVENT THIS CONFUSION.

IN REGARD TO MAINTAINING THE CURRENT LANGUAGE, I CANNOT OVEREMPHASIZE THE FACT THAT WE BELIEVE THE CURRENT PROGRAM HAS BEEN EXTREMELY PRODUCTIVE AND TO MODIFY IT WOULD BE A MISTAKE. ONE PIECE OF MANPOWER LEGISLATION INTRODUCED IN THE SENATE--S. 2144--PROVIDES THAT AS A CONDITION TO THE RECEIPT OF GRANT FUNDS, RESIDENCY PROGRAMS MUST BE AFFILIATED WITH A MEDICAL SCHOOL. SOME OF THE BEST FAMILY PRACTICE RESIDENCY PROGRAMS ARE IN COMMUNITY HOSPITALS NOT AFFILIATED WITH MEDICAL SCHOOLS AND THE ACADEMY IS VERY STRONGLY OPPOSED TO THIS PROVISION. A RECENT SURVEY OF FAMILY PRACTICE RESIDENCY PROGRAMS BY AN ASSISTANT DEAN AT THE UNIVERSITY OF WISCONSIN--MADISON, INDICATES THAT THE RESIDENCY PROGRAMS SHARE OUR POSITION. OUT OF 184 PROGRAMS RESPONDING, 161 INDICATED THEY HAD SOME TYPE OF MEDICAL SCHOOL AFFILIATION. HOWEVER, WHEN ASKED IF THEY WOULD WELCOME LEGISLATION WHICH WOULD GIVE FAMILY PRACTICE RESIDENCY MONEY TO MEDICAL SCHOOLS AND THEN LET THEM DISPENSE IT TO COMMUNITY HOSPITALS, 134 SAID "NO", 17 SAID "YES" AND 3 EXPRESSED NO OPINION.

OPTIONAL MEDICARE AND MEDICAID REIMBURSEMENT

BEFORE BRIEFLY DISCUSSING OTHER ASPECTS OF PENDING HEALTH MANPOWER LEGISLATION, I WOULD LIKE TO MENTION ONE OTHER PROVISION IN H.R. 6802 WHICH IS OF PARTICULAR INTEREST TO THE ACADEMY IN ITS EFFORTS TO PROMOTE AND STRENGTHEN OUR RESIDENCY TRAINING PROGRAMS.

THIS PROVISION WOULD AMEND TITLE XVIII OF THE SOCIAL SECURITY ACT TO PROVIDE THAT RESIDENTS WHO ARE LICENSED TO PRACTICE AND WHO ARE TRAINING IN GENERAL INTERNAL MEDICINE, GENERAL PEDIATRICS OR FAMILY MEDICINE MAY BILL ON A REASONABLE CHARGE BASIS FOR THOSE OUTPATIENT SERVICES PROVIDED IN THE PRIMARY CARE TRAINING CENTER. BASED ON DISCUSSIONS WITH FAMILY PRACTICE RESIDENCY PROGRAM DIRECTORS, IT IS OUR UNDERSTANDING THAT CURRENT MEDICARE LAW CREATES SIGNIFICANT DIFFICULTIES FOR SUCH PROGRAMS.

UNDER PRESENT LAW, MEDICAL RESIDENTS CANNOT BILL MEDICARE PATIENTS FOR SERVICES RENDERED AND SALARIES FOR SUCH RESIDENTS ARE INCLUDED AS PART OF THE HOSPITAL'S REASONABLE COSTS. THIS RULE DOES NOT APPLY IF SERVICES ARE PROVIDED OFF PROVIDER PREMISES, IN WHICH CASE SERVICES PROVIDED BY RESIDENTS ARE REIMBURSED ON A REASONABLE CHARGE BASIS.

INTERMEDIARY LETTER 372 RECOGNIZES THERE ARE INSTANCES IN THE TEACHING SETTING WHEN THE PATIENT IS SEEN BY HIS OR HER PERSONAL PHYSICIAN AND SETS FORTH CRITERIA WHICH A PHYSICIAN MUST MEET TO QUALIFY AS AN ATTENDING PHYSICIAN AND BILL ON A REASONABLE CHARGE BASIS. ATTENDING PHYSICIANS MAY THEN BILL FOR SERVICES PROVIDED BY THEM OR BY RESIDENTS UNDER THEIR PERSONAL SUPERVISION.

WHILE WE ARE NOT AWARE THAT THIS HAS CREATED PROBLEMS IN THE INPATIENT SETTING OR FOR INPATIENT-BASED RESIDENCY PROGRAMS, IT HAS CREATED A DIFFICULT SITUATION FOR FAMILY PRACTICE RESIDENCY PROGRAMS. THE HEART OF THIS TYPE OF RESIDENCY TRAINING IS THE MODEL FAMILY PRACTICE UNIT WHICH IS MODELED AFTER THE PHYSICIAN'S OFFICE AND PROVIDES OUTPATIENT SERVICES IN THE SAME WAY THEY WOULD

BE PROVIDED BY A PHYSICIAN IN PRIVATE PRACTICE. ESSENTIAL TO THIS TRAINING APPROACH IS THE CONCEPT THAT THE FAMILY PRACTICE RESIDENT FUNCTIONS AS THE PERSONAL PHYSICIAN FOR A DEFINED GROUP OF PATIENTS. BECAUSE THEY ARE RESIDENTS, THEY CANNOT BILL AS WOULD A PERSONAL PHYSICIAN BUT BECAUSE THEY ARE FUNCTIONING AS THE PERSONAL PHYSICIAN, THE TEACHING PHYSICIAN CANNOT MEET THE CRITERIA OF AN ATTENDING PHYSICIAN AND BILL FOR THOSE SERVICES PROVIDED BY RESIDENTS UNDER HIS SUPERVISION.

WE BELIEVE THE MEDICARE AMENDMENT PROPOSED IN H.R. 6802 WOULD CORRECT THE CURRENT PROBLEM. AT THE SAME TIME, WE ARE CONCERNED THAT IT NOT RESULT IN CREATING A SITUATION WHEREBY MEDICARE WOULD PAY BOTH REASONABLE CHARGES AND REASONABLE COSTS FOR THE SAME SERVICE. ACCORDINGLY, WE FULLY EXPECT THAT IF THIS AMENDMENT BECOMES LAW, STEPS WOULD HAVE TO BE TAKEN IN ITS IMPLEMENTATION TO ENSURE THAT SUCH DOUBLE BILLING DOES NOT OCCUR, INCLUDING PROMULGATION OF THE REQUIREMENT THAT IF A HOSPITAL ELECTS TO ADOPT THIS SYSTEM FOR SERVICES PROVIDED IN THE PRIMARY CARE TRAINING CENTER, NO PART OF THE SALARIES PAID TO RESIDENTS OR TEACHING PHYSICIANS FOR TIME SPENT IN THE CENTER COULD BE INCLUDED IN THE HOSPITAL'S REASONABLE COSTS. THIS IS CONSISTENT WITH A RECOMMENDED EXPERIMENTAL PAYMENT METHOD IN THE INSTITUTE OF MEDICINE'S 1976 REPORT ON MEDICARE/MEDICAID REIMBURSEMENT POLICIES.

GMENAC

WE NOTE THAT BOTH H.R. 6802 AND S. 2375 PROVIDE FOR THE ESTABLISHMENT OF THE GRADUATE MEDICAL EDUCATION NATIONAL ADVISORY

COUNCIL AS A STATUTORY COUNCIL. THE ACADEMY CONCURS WITH THE AUTHORS OF THESE PROPOSALS THAT IT IS A DESIRABLE OBJECTIVE TO ENSURE THAT KNOWLEDGABLE INDIVIDUALS OUTSIDE THE GOVERNMENT HAVE A ROLE IN ASSESSING THE NATION'S HEALTH MANPOWER NEEDS ON AN ONGOING BASIS. THE ACADEMY IS IMPRESSED BY WHAT GMENAC HAS ACCOMPLISHED TO DATE AND BELIEVES IT IS APPROPRIATE THAT THIS BODY CONTINUE TO FUNCTION IN THE FUTURE. ALTHOUGH FAMILY PRACTICE HAS BEEN REPRESENTED ON GMENAC, WE SUGGEST THAT CONSIDERATION BE GIVEN TO STATUTORILY DEFINING ITS COMPOSITION TO ENSURE REPRESENTATION BY FAMILY PHYSICIANS.

STUDENT ASSISTANCE AND THE NATIONAL HEALTH SERVICE CORPS

INFLATION, THE EVER-INCREASING COST OF TUITION AND HIGH INTEREST RATES ON LOANS HAVE PLACED AN EXTREME FINANCIAL BURDEN ON MEDICAL STUDENTS, MAKING FEDERAL LOANS ESSENTIAL TO MANY STUDENTS. THE ACADEMY IS ESPECIALLY CONCERNED THAT MUCH OF THE INCREASE IN TUITION IN RECENT YEARS HAS BEEN CAUSED BY INCREASED MEDICAL SCHOOL EXPENDITURES WHICH ARE NOT DIRECTLY RELATED TO THE COST OF PROVIDING MEDICAL EDUCATION. IF TUITION CONTINUES TO RISE UNCHECKED, NO PROGRAM OF STUDENT LOANS WILL SUFFICE AND, FOR THIS REASON, THE ACADEMY BELIEVES THAT IN THE FUTURE, SCRUTINY MUST BE GIVEN TO THE CAUSES FOR HIGH TUITION FEES AND FURTHER TUITION INCREASES.

THE ACADEMY SUPPORTS A PLURALITY OF FUNDING SOURCES TO ENABLE QUALIFIED STUDENTS WITH MODEST MEANS TO OBTAIN A MEDICAL EDUCATION. ACCORDINGLY, WE SUPPORT CONTINUATION OF THE HEAL PROGRAM OF PRIVATE LOANS GUARANTEED BY THE FEDERAL GOVERNMENT AND CONTINUATION OF THE EXCEPTIONAL FINANCIAL NEED SCHOLARSHIP PROGRAM.

We recognize there are areas in the United States where young physicians will not voluntarily establish practices because of economics, geography and unavailability of specialty back-up. We believe these areas are better served medically by well-trained National Health Service Corps physicians than by allied personnel and we support the retention of the National Health Service Corps Scholarship Program. We support language eliminating the income equivalence test in order that a National Health Service Corps physician may select the private practice option and we support requiring the Secretary of HEW, before placing a federally paid health professional in an area, to determine that a service obligated physician is not available to enter the area under the private practice option. We believe that adoption of these proposals will improve the likelihood that national health service corps physicians will practice in underserved areas of their choosing and thereby improve the likelihood they will remain in those areas upon completion of their service obligation. We are opposed to a requirement for service obligated professionals to accept Medicare patients on assignment under the private practice option.

One proposal which has been advanced in S. 2375 would create a student loan program whereby students accepting loans would be subject to a national lottery during a specified period of time following graduation from medical school. The number called to service at any given time would depend on the perceived national needs at that time and the loans for those called would be forgiven. The Academy favors student loans as a means of encouraging physicians

TO VOLUNTARILY AGREE TO PRACTICE IN AN UNDERSERVED AREA OF THEIR OWN CHOOSING, WITH LOAN INCENTIVES BASED ON THE AMOUNT OF TIME THE PHYSICIAN PRACTICES IN THE AREA. HOWEVER, WE ARE OPPOSED TO ANY LOAN PROGRAM WHICH WOULD SUBJECT LOAN RECIPIENTS TO A LOTTERY AND THE UNCERTAINTY OF BEING UNABLE TO MAKE CAREER DECISIONS UNTIL SUCH TIME AS THE PHYSICIAN IS NO LONGER SUBJECT TO THE LOTTERY. IN ADDITION, WE SUSPECT THIS TYPE OF PROPOSAL WOULD HAVE THE UNINTENDED RESULT OF EXACERBATING SPECIALTY MALDISTRIBUTION PROBLEMS. THAT IS, IT WOULD SEEM THAT PRIMARY CARE PHYSICIANS WOULD BE MUCH MORE LIKELY TO BE CALLED TO SERVICE UNDER THIS TYPE OF PROGRAM AND A MEDICAL STUDENT HAVING TO DECIDE BETWEEN ACCEPTING THE LOAN OR NOT GOING TO MEDICAL SCHOOL MAY LOGICALLY DETERMINE HIS BEST OPTION IS TO ACCEPT THE LOAN AND ENTER A SUBSPECIALTY.

INSTITUTIONAL SUPPORT

RECOGNIZING THAT CAPITATION SUPPORT FOR MEDICAL SCHOOLS MAY BE SUBSTANTIALLY CURTAILED IF NOT COMPLETELY ELIMINATED AND RECOGNIZING THAT AN ABSENCE OF SOME TYPE OF FEDERAL SUPPORT MAY CREATE A FINANCIAL CRISIS FOR MEDICAL SCHOOLS AND MEDICAL STUDENTS FACED WITH INCREASED TUITION COSTS, THE ACADEMY BELIEVES SOME ALTERNATIVE TYPE OF INSTITUTIONAL SUPPORT MUST BE ESTABLISHED. WE BELIEVE IT IS APPROPRIATE TO CONDITION INSTITUTIONAL SUPPORT ON THE ATTAINMENT OF SPECIFIC GOALS AND, THEREFORE, BELIEVE THE INSTITUTIONAL SUPPORT PROGRAM PROPOSED IN S. 2375 PRESENTS SUCH AN ALTERNATIVE. UNDER THIS PROGRAM, THE CAPITATION AMOUNT FOR ANY SCHOOL WOULD BE BASED ON THE ACCOMPLISHMENT OF SPECIFIC OBJECTIVES WITH REDUCTIONS IN THE AMOUNT FOR ACHIEVING UNDESIRABLE RESULTS.

Among the objectives of this program which we specifically support are increasing the number of under-represented minority groups, increasing the number of students entering family practice and primary care and increasing the number of students eventually practicing in underserved areas. We also favor a new authority contained in S. 2375 which would authorize grants for long term but time limited support for national priority schools meeting the needs of minority population groups.

Special Project Grants and Contracts

In addition to the previously discussed special project grants for family practice, we support continuation of the area health education center program and authorities for allied health projects, but believe new roles and types of health workers should be de-emphasized. Further, we support proposed special project grants to provide clinical training in remote sites which serve medically underserved populations, to provide support services to physicians practicing in medically underserved areas and to evaluate continuing education and develop innovative approaches to providing such education.

Mr. Chairman, this concludes my statement. I would like to thank you and the members of the subcommittee for giving me the opportunity to present the Academy's views. At this time, I will be happy to answer any questions which you might have.

ATTACHMENT A

AAFP Reprint No. 150

RESULTS OF ANNUAL SURVEY OF FAMILY PRACTICE RESIDENCY PROGRAMS

August, 1979

I. Programs:

A. Total Approval Programs		364
B. Total Operating Programs (9 approved but not operating)		355
Community Hospital Based	57	
University Based	62	
University Affiliated or Administered	228	
Military Hospital Based	17	

II. Residents:

A. Total Residents		6,531
1. Total First Year Residents	2,360	
2. Total Second Year Residents	2,205	
3. Total Third Year Residents	1,966	
B. Total Approved First-Year Positions		2,500
C. First Year Fill Rate		94.4%

D. Increase/Decrease Class Size by Year

	1977-78	1978-79	1979-80
Class of '80	2,043	1,986	1,966
Class of '81	-----	2,318	2,205
Class of '82	-----	-----	2,360

III. Residency Graduates:

A. Total July, 1979 residency graduates	1,724
B. Total graduates from family practice residency programs since January 1, 1970	6,666

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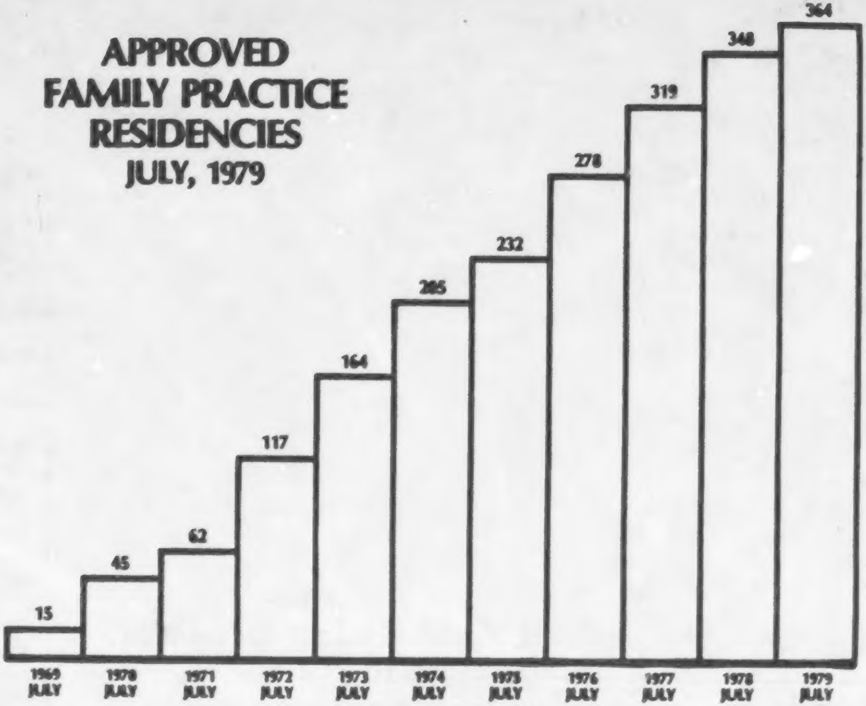
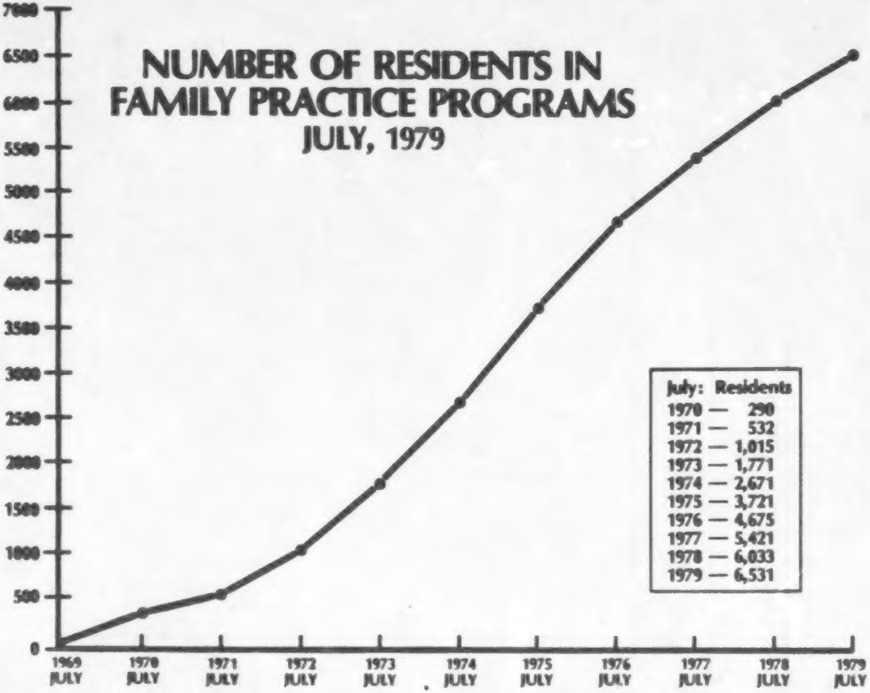


APPROVED FAMILY PRACTICE RESIDENCIES JULY, 1979

The American Academy of Family Physicians

AAFP 150-B



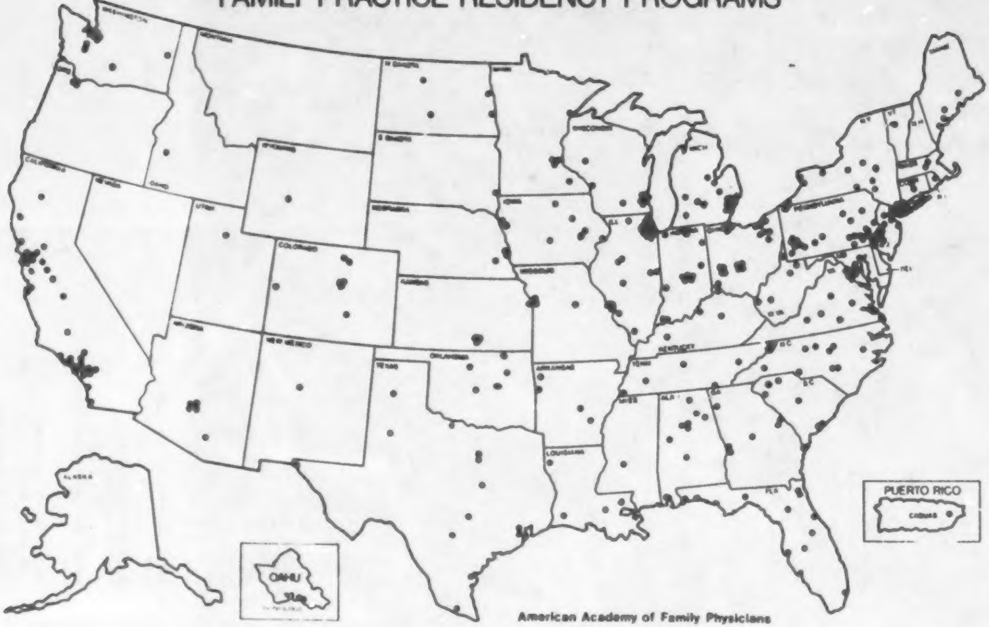
NUMBER OF RESIDENTS IN FAMILY PRACTICE PROGRAMS
JULY, 1979

July:	Residents
1970 —	290
1971 —	532
1972 —	1,015
1973 —	1,771
1974 —	2,671
1975 —	3,721
1976 —	4,675
1977 —	5,421
1978 —	6,033
1979 —	6,531

The American Academy of Family Physicians

AAFP 150-C

FAMILY PRACTICE RESIDENCY PROGRAMS


WASHINGTON
MONTANA
N DAKOTA
S DAKOTA
WYOMING
IDAHO
CALIFORNIA
NEVADA
UTAH
COLORADO
NEBRASKA
KANSAS
ARIZONA
NEW MEXICO
TEXAS
OKLAHOMA
IOWA
MISSOURI
ARKANSAS
LOUISIANA
WISCONSIN
MICH
ILL
KENTUCKY
TENN
MISS
ALA
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S C
PENNSYLVANIA
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ALASKA
OAHU
PUERTO RICO
CAGUAS

American Academy of Family Physicians

AAFP Reprint No. 155E

ATTACHMENT B

American Academy of Family Physicians

REPORT ON SURVEY OF
1979 GRADUATION FAMILY PRACTICE RESIDENTS

The total number of graduates surveyed was 1,724. Of this number, 1,567 (90.9%) responded. Of these respondees, 1,443 indicated type of practice arrangement and 1,345 specified the size of the community which they plan to serve. A summary of the results as of July, 1979, follows.

Caution must be exercised in comparing 1977, 1978 and 1979 demographic data with demographic data from previous years because modifications were made in 1977 in the criteria discribing character and population of communities to which graduating residents were moving to practice. However, 1977-1979 data may be directly compared with confidence.

PRACTICE ARRANGEMENTS OF 1979 GRADUATING RESIDENTS

Type of Practice Arrangement	Number of Reporting Grads	Percentage of Total Reporting Grads
Family Practice Group	419	29.1%
Multi-Specialty Group	119	8.2%
Two-Person Family Practice Group (Partnership)	261	18.1%
Solo	186	12.9%
Military	159	11.0%
Teaching	68	4.7%
USPHS	104	7.2%
Emergency Room	64	4.4%
Hospital Staff (F-T)	31	2.2%
None of the above	32	2.2%
	1,443	100.0%

DISTRIBUTION OF 1979 GRADUATING RESIDENTS BY COMMUNITY SIZE

Character and Population of Community	Number of Reporting Grads	Percentage of Total Reporting Grads	Cumulative Percentage of Total Reporting Grads
Rural area or town (less than 2500) not within 25 miles of large cities	80	5.9%	5.9%
Rural area or town (less than 2500) within 25 miles of large city	38	2.8%	8.7%
Small town (2500-25,000) not within 25 miles of large city	325	24.2%	32.9%
Small town (2500-25,000) within 25 miles of large city	214	15.9%	48.8%
Small City (25,000-100,000)	213	15.8%	64.6%
Suburb of small metropolitan area	49	3.7%	68.3%
Small metropolitan area (100,000-500,000)	143	10.6%	78.9%
Suburb of large metropolitan area	123	9.2%	88.1%
Large metropolitan area (500,000 or more)	106	7.9%	96.0%
Inner city/low income area (500,000 or more)	54	4.0%	100.0%
	1,345	100.0%	

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AAFP Reprint No. 155D

American Academy of Family Physicians

REPORT ON SURVEY OF
1978 GRADUATING FAMILY PRACTICE RESIDENTS

The total number of graduates surveyed was 1,548. Of this number, 1,385 (89.5%) responded. Of these respondees, 1,359 indicated type of practice arrangement and 1,082 specified the size of the community which they plan to serve. A summary of the results as of August 1978, follows.

Caution must be exercised in comparing 1977 and 1978 demographic data with demographic data from previous years because modifications were made in 1977 in the criteria describing character and population of communities to which graduating residents were moving to practice. However, 1978 and 1977 data may be directly compared with confidence.

PRACTICE ARRANGEMENTS OF 1978 GRADUATING RESIDENTS

Type of Practice Arrangement	Number of Reporting Grads	Percentage of Total Reporting Grads
Family Practice Group	411	30.2%
Multi-Specialty Group	138	10.2%
Two-Person Family Practice Group (Partnership)	262	19.3%
Solo	185	13.6%
Military	130	9.6%
Teaching	70	5.1%
USPHS	61	4.5%
Emergency Room	12	0.9%
Hospital Staff(F-T)	51	3.8%
None of the above	39	2.8%
	1,359	100.0%

DISTRIBUTION OF 1978 GRADUATING RESIDENTS BY COMMUNITY SIZE

Character and Population of Community	Number of Reporting Grads	Percentage of Total Reporting Grads	Cumulative Percentage of Total Reporting Grads
Rural area or town (less than 2500) not within 25 miles of large cities	91	8.4%	8.4%
Rural area or town (less than 2500) within 25 miles of large city	34	3.1%	11.5%
Small town (2500-25,000) not within 25 miles of large city	257	23.8%	35.3%
Small town (2500-25,000) within 25 miles of large city	183	16.9%	52.2%
Small city (25,000-100,000)	186	17.2%	59.4%
Suburb of small metropolitan area	38	3.5%	72.9%
Small metropolitan area (100,000-500,000)	90	8.3%	81.2%
Suburb of large metropolitan area	103	9.5%	90.7%
Large metropolitan area (500,000 or more)	72	6.7%	97.4%
Inner city/low income area (500,000 or more)	28	2.6%	100.0%
	1082	100.0%	

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AAFP Reprint No. 420

DISTRIBUTION OF NONFEDERAL PHYSICIANS IN PATIENT CARE* – 1931 through 1978

Year	*Civilian Pop.*	*Total MDs in Patient Care*	*FP/GPs in Patient Care*		*Other Spec. in Patient Care*	
			No.	*%*	*No.*	*%*
1931	123,886,000	134,274	112,116	83	22,158	17
1940	131,658,000	142,939	109,272	76	33,667	24
1949	147,578,000	150,417	95,526	64	54,891	36
1960	177,472,000	165,844	74,553	45	91,291	55
1965	192,956,000	239,262	67,510	28	171,752	72
1968 (1)	198,204,000	238,481	56,245	24	182,236	76
1969	200,391,000	247,508	54,508	22	193,000	78
1970	203,046,000	255,027	54,098	21	200,929	79
1971	205,497,000	263,730	52,862	20	211,868	80
1972	207,313,000	269,095	52,330	19	216,865	81
1973	208,950,000	272,850	50,786	18.6	222,064	81.4
1974	210,600,000	278,517	50,935	18.3	227,582	81.7
1975	212,200,000	287,837	51,270	17.8	236,567	82.2
1976	213,800,000	294,730	52,054	17.7	242,676	82.3
1977	213,925,000	315,745	52,062	16.5	263,683	83.5
1978	215,666,000	325,783	53,019	16.3	272,764	83.7

*Figures prior to 1965 were termed "private practice"

(1) Reclassification of physicians in 1968 responsible for drop in "patient care" totals.

Sources: AMA Distribution of Physicians and U.S. Department of Commerce Population Estimates and Projections

ATTACHMENT C

Mr. **Waxman**. Thank you very much.

STATEMENT OF TERRY KANE, M.D.

Dr. **Kane**. Mr. Chairman, Dr. Carter, I appreciate the opportunity to speak with you this morning. I am a graduate of a family medicine residency program, one of the 15 early programs Dr. Chaney mentioned.

I believe the partnership between family medicine educational programs and the Government has certainly been mutually rewarding. Federal support for residency programs, faculty development, and predoctoral activities in family medicine and now departmental support for family medicine have been absolutely essential to the development of family medicine as an academic discipline.

It is my opinion that with this continued Federal support, family medicine education as we now know it cannot continue to prosper. Although it was originally hoped that funding from the Federal Government would allow programs in family medicine to eventually develop secure sources of support, particularly from patient care income, these other sources have proved insufficient to offset the costs of educational and research activities in the ambulatory setting.

Because of reimbursement levels in the United States for family physicians, it is certain that patient care income at this time cannot provide sufficient support for an educational program in family medicine. It is generally accepted that patient care income is currently able to support approximately 30 percent of total program costs in family practice residency programs.

Our programs are principally ambulatory based in family medicine centers where fees must remain competitive with other noneducational practices in the community. Until such time as reimbursement for primary care reaches parity with our more technical specialties, continued support from the Federal Government appears necessary.

With particular reference to the new health manpower legislation, I would make the following comments. Continued support must be available for residency and predoctoral programs in family medicine. This money is essential to sustain what has already been accomplished and to continue to supply family physicians for underserved areas of our country.

I particularly support the funding for departments of family medicine to allow them to achieve parity with other clinical departments in our medical schools. These funds will allow departments of family medicine to develop research expertise as well as to strengthen their educational and clinical programs to successfully compete in the medical school environment.

I also agree with the academy and strongly oppose any attempts to place all funding for family medicine graduate education programs in our medical schools. I believe this would damage an already successful system of giving the money directly to our community hospital-based programs.

Finally, I would hope Congress would study the financing of medical education in the ambulatory setting by examining patient care income and other ways to offset the tremendous advantage that our hospital-based specialties have in this regard. The reimbursement imbalance continues to be an opposing force to increased emphasis on primary care in general and family medicine in particular.

Once again, I thank you for the opportunity to speak to you. I am speaking for the Society of Teachers of Family Medicine, which is an organization which represents more than 2,000 multidisciplinary faculty of our programs in this country.

We believe we have fulfilled your expectations of producing family physicians for the United States and look forward to working with you in the future.

Dr. **Waxman**. Thank you.

Dr. Delbanco.

STATEMENT OF THOMAS L. DELBANCO, M.D.

Dr. **Delbanco**. Mr. Chairman, Dr. Carter, I am an internist and teach medicine at Harvard. I was privileged to be here 2 years ago as a Johnson health policy fellow and had the more comfortable experience of sitting behind, rather than in front of you.

I might mention, Dr. Carter, I didn't go into obstetrics, and that happened in part because where I went to medical school there were 18 floors, and the O.B. floor was the 16th. Pelvimetry was on the third floor. I took a woman down in labor once to the third floor. The foot came out, and by the time we got to the 16th floor, she was screaming, I was screaming, and I had decided I wasn't going to be an obstetrician.

Dr. **Carter**. You did have obstetrical training while you were in school.

Dr. **Delbanco**. That is right.

I am excited by this bill because of two things I think it does. One is, I think it corrects some of the imbalance we have between generalists and specialists. Second, I think in an indirect way it will actually serve as a cost containment measure.

Let me make four brief points. One is that the manpower legislation has done a lot already. If I told my colleagues at Harvard 5 years ago that now 30 percent of trainees at Harvard in internal medicine would be in special primary care programs, they literally would have thought I was hallucinating. Yet that is the case today.

The law has made enormous changes. Last year 81 programs training general internists and general pediatricians were funded by the Government. They have been spreading across the country.

The second thing is that we have to prepare more faculty in general medicine. I cannot stress strongly enough the importance of the role model in the medical center. When you go to medical school now, you see the cardiologist, you see the nephrologists, and you see the elegant surgeons. But until recently students do not see general doctors. The fact that we are now beginning to run training programs to give proper academic and teaching credentials to generalists cannot be overstated. The legislation you are proposing moves this authority into general internal medicine and pediatrics, and I think it is a very important step.

The law proposes a change in reimbursement which is also important. If I ran a hospital, and the professor of urology came to me and said he would like to hire a few more residents to train more urologists, I would be delighted. I could then make a pretty safe bet that as a result I would fill more hospital beds and keep the operating room a bit busier.

On the other hand, if the primary care professor comes and says he would like to train generalists to care for more patients in the outpatient department, while doing his best to keep the patients he is serving out of the hospital, I might not be so thrilled.

In particular, I might be very worried because the house officer caring for those patients who can still walk and talk cannot charge a physician's fee which third parties will honor. So everyone is in trouble. Present insurance patterns leave both the patient and the hospital at risk. The primary care training programs suffer the consequences.

This legislation addresses this issue and proposes that medicare and medicaid begin to recognize explicitly the cost of teaching young physicians to be generalists, and that is a good idea.

There is another ripple effect that this legislation addresses. I don't know if you realize it, but one out of every four visits to a doctor today is to a hospital outpatient department.

Hospital clinics have been an abomination in the past. They were the last place you would choose to go for ongoing medical care if you had any choice.

But training programs which hope to produce good primary care physicians use the outpatient department, and they learn quickly that you cannot attract young physicians into careers in primary care if you try to seduce them in a setting where patients do not get good care.

So already many of the programs, such as the one in which I work, have led to much better care for the poor and undeserved in the outpatient setting. Some of these model programs now—and we hope someday they won't be models any more, but will be built into the institutional fabric—are really making quite a change in the services hospitals offer.

We become patient advocates, and this is another point I would like to emphasize. We keep our patients out of the hospital beds, not just because we are cost conscious, but because we have learned, and we teach, that the best medical care need not be centered in the hospital. Our students learn quickly that patients, and particularly elderly patients, sometimes fall apart in a hospital bed. Frequently the biggest favor we can do our patients is to manage them as outpatients.

It doesn't make sense to teach doctors the way I was taught. My role models in the past thought that good medical care means hospitalizing a sick patient. What I have now learned is that good medical care means more often than not, keeping the patient out of the hospital. That is what we are teaching the students in the programs you have funded.

We also spend a lot of time teaching our students to think critically about the cost implications of their practice: Do they really need to order that expensive X-ray right away, or can they wait to see what happens to abdominal pain over time? We teach our doctors what not to order. On the wards, the traditional trainee still orders everything in the world to see if something will turn up.

You can see why hospital administrators sometimes view us with a jaundiced eye. That is why you must help assure the hospital of relatively stable funding for primary care training programs. They are still not quite sure they want them around, and I think this legislation makes a first and important step in giving a much more secure foundation for such programs.

Thank you very much.

[Testimony resumes on p. 370.]

[Dr. Delbanco's prepared statement follows:]

A STATEMENT

by

Thomas L. Delbanco, M.D.
Chief, Division of General Medicine
and Primary Care
Beth Israel Hospital
Associate Professor of Medicine
Harvard Medical School

My name is Thomas Delbanco. I am a board certified, general internist; Associate Professor of Medicine at Harvard Medical School; and Chief of the Division of General Medicine and Primary Care at Beth Israel Hospital, one of the Harvard teaching hospitals. I am also Director of the Henry J. Kaiser Fellowship Program in General Medicine at Harvard Medical School, a program which is preparing general internists for careers as teachers and scholars in primary care and general medicine. I might also mention that two years ago I was privileged to work in the Congress as a Robert Wood Johnson Health Policy Fellow.

When the availability of primary health services reached its low point ten years ago, the American public seemed to wake up and notice that we were preparing too many subspecialists and too few general physicians. The doctor who used to care for us when we were growing up had disappeared, and he was being replaced by doctors with skills in sharply circumscribed areas. We noticed also that medical care was getting very expensive. Medical technology was exploding and proliferating. A new test was invented every week. Physicians were using more and more gadgets and charging a lot for their use.

What excites me about the legislation we are discussing is that it addresses two issues head on: the imbalance between generalists and specialists, and the mounting costs of health care. The impulse behind training programs in primary care is to stimulate us to turn out more general physicians and, by implication, fewer subspecialists. It is my sense that if we do that, we may have a real chance to improve health care and at the same time keep down some of the costs that frighten us all today.

What have the training programs in general internal medicine and pediatrics done so far? Stimulated first by private philanthropy and then by the Health Professions Educational Assistance Act (94-484) in 1976, medical schools have mounted exciting programs which have attracted more and more young physicians into primary care. If I had told my colleagues at Harvard five years ago that in 1979, 30 percent of trainees in Harvard internal medicine programs would choose special programs preparing them for careers in primary care, they would have thought I was hallucinating. But that is the case today, and the legislation should help maintain this momentum and help us move further ahead. Last year, 81 programs were supported by the government, and it is extraordinary to watch how primary care has taken an important role in even some of our most conservative health science centers.

In addition to giving further support for the teaching programs that are now underway, the proposed Amendments of 1980 move into two new areas. The first is that you propose to fund programs to train future faculty for careers in general internal medicine and pediatrics. I am presently directing such a program in the Division of Primary Care and Family Medicine at Harvard with the support of the Henry J. Kaiser Family Foundation. In recent years, the Robert Wood Johnson Foundation, and more recently the Kaiser Foundation have helped establish several programs for preparing such faculty. We need federal support. I cannot overstate the importance of the faculty role model in the academic health science center. There are few of us in medicine who cannot point to one or two individuals who had a remarkable influence on our subsequent careers. I believe that one of the principal reasons it has been so difficult to get our young doctors to enter primary care is the fact that these role models have just not existed at the medical school in recent times. Slowly but surely the academically accomplished young generalist is emerging. We have to train more of them, and I suspect that the money you spend in this area will have an enormous payoff for our society. It will have a ripple effect in terms of attracting the young physician into primary care that will far exceed its initial cost.

The proposed legislation for 1980 for the first time addresses explicitly some of the economic forces that play such an important role in health care. The incentive system in health today rewards the wrong things. How can I make the most money? I can order too many laboratory tests; I can put too many people in the hospital; I can certainly make sure that I not give care to the poor and underserved. This has important implications for primary care training programs. Why? Because for the most part they are, and in my opinion should be, located at the academic health science center - and more specifically in the outpatient clinic. And at the hospital, the incentives are just as confused.

Let me give an example of why this is important. If I run a hospital, and the professor of urology comes to me and says he would like to hire a few more residents to train more urologists, I am delighted, because I can make a pretty safe bet that over time I shall fill more hospital beds and keep the operating room a little busier. On the other hand, if the primary care professor comes and says he would like to train more generalists and care for more patients in the outpatient department, and by the way do his best to keep the patients he is serving out of the hospital, I might not be so thrilled. In particular, I may be very worried because the house officer caring for patients who can still walk and talk can often not charge a physician's fee which third-party payers will honor.

So everyone is in trouble. Present insurance patterns leave both the patient and the hospital at risk. The primary care training program suffers the consequence.

The legislation addresses this issue and proposes that Medicare and Medicaid begin to recognize explicitly the cost of teaching young physicians to be generalists. It says that Medicare and Medicaid should help pay for the frequently superb care that these trainees provide.

There is yet another ripple effect. It is an extraordinary fact that today almost one out of every four visits to a doctor is to a hospital outpatient department. Hospital clinics have been an abomination in the past. They were the last place you would choose to go for ongoing medical care if you had any choice. But training programs which hope to produce good primary care doctors use primarily the outpatient departments, and they learn very quickly that you cannot attract the young into careers in primary care if you try to seduce them in a setting where patients do not receive excellent care. We can see already that these training programs have been crucial for improving the care the clinic gives. Moreover, the academic health science center often serves the inner city, or is the focal point for widespread rural populations. The most successful programs are integrating care in one setting for both the underprivileged and the more fortunate. We all know that separate but equal has never worked very well in our country. This is just as true in medical care as in the public schools on which we have focused.

What else happens? In these settings we very rapidly become the patient's advocate. We keep our patients out of those expensive hospital beds, not just because we are cost conscious, but because we have learned that the best medical care need not be centered on the hospital wards. Our students learn quickly that patients, and particularly the elderly, sometimes fall apart in the hospital bed. Frequently the biggest favor we can do our patients is to manage them as outpatients. It does not make sense to teach doctors the way I was taught. I thought that good medical care meant hospitalizing a sick patient. I have learned by now that good medical care more often than not means keeping the patient out of the hospital. That is what we teach our students in the programs you have funded.

In these programs we do not profit from the laboratory tests we order. We spend a lot of time teaching our students to think critically about the cost implications of their practices. Do they really need to order that expensive x-ray right now, or can they perhaps afford to wait awhile and see what happens to abdominal pain over time? In our primary care programs we teach our doctors what not to order; on the wards the traditional trainee sometimes orders everything in the world to see if something will turn up.

You can see why hospital administrators sometimes view us with a jaundiced eye. This is why you must assure the hospital of relatively stable funding for primary care training programs. They are still not quite sure they want them around. I think this legislation would take a first and important step in giving a much more secure foundation for such programs. I applaud these efforts.

Mr. **Waxman**. Thank you very much.

Dr. Kane and Dr. Delbanco, you are both members of a faculty. I am interested in hearing from you about the training programs in family practice. What do you do specifically that is different from the traditional internal medicine, pediatrics, or even surgery training programs?

If primary care is real, as Dr. Estes told us earlier today, how do you teach it to young physicians?

Dr. **Delbanco**. In internal medicine, when I grew up I spent about 10 percent of my time caring for ambulatory patients, even though the practicing doctor spends in general more than half of his time doing that, even if he is a subspecialist in medicine.

In the program that I run, at Harvard the trainees spend 25 to 30 percent of their time in ambulatory care. They learn more than the office practice of internal medicine. They learn to put in an IUD. They learn a lot about mental health. They learn to do minor surgery in the emergency room, aspects of dermatology, ear, nose, throat, ophthalmology, et cetera.

They are much better-rounded physicians, I think. They are less of a switchboard. They need help less frequently. The biggest change we have made is this large emphasis on ambulatory care, rather than the traditional training which was all on the wards.

Dr. **Kane**. My experience has been very similar using a family medicine center. I would concur with Dr. Delbanco. It is really the emphasis on ambulatory care. In our programs the major factor is when the resident first enters the program, they are assigned a group of families for whom they are responsible for the next 3 years. They are the responsible physician. I think that is a major difference.

I think the other biggest difference I see is the emphasis in the ambulatory setting on the behavioral and humanistic aspects of medicine, and again, with the emphasis on trying to be as cost-effective. In the hospital setting, most people have insurance; in our setting, in the ambulatory setting, many people do not.

Therefore, you must be very critical in your use of tests and also the use of the hospital. So, very similar, the emphasis on ambulatory care and the continuing responsibility for patients. It can be taught using sophisticated techniques such as closed circuit television and video taping to see what actually the patient and the physician encounter.

There are many other facets. It can be taught. It is being taught. I think our graduates can prove that. There is one other statement. I would say we still have a major problem. Each time we want to expand the amount of time spent in the ambulatory setting, we have very little ways to spend and pay for that time, both faculty and learners in that setting. It is an expensive setting.

Our whole reimbursement setting is set up to pay for people to be in the hospital while they are learning, so we always run into that problem.

Mr. **Waxman**. Dr. Chaney, last year family medicine programs received over 3,000 applications for 2,500 first-year positions. This means there were hundreds of young physicians who wanted to enter family practice for which there were no positions.

In your statement you noted that there are currently family medicine physicians to accommodate 17 percent of first-year residents, that your goal is to be able to accommodate 25 percent. Do you know how much the existing Federal grant program would need to be increased to make that possible?

Dr. CHANEY. I don't have the figure, but if you calculate the number of medical school graduates and try to take 25 percent of those, we will need to increase our first-year residency positions by 1,600. What that would cost, I really don't know. That is not an area in which I am an expert. Do you know, Terry, the cost of establishing 1,600 new residency programs?

[Dr. Kane nods negatively.]

Mr. WAXMAN. If you don't know off-hand, you could furnish the information for the record. I think it would be helpful to have.

Dr. CHANEY. Surely.

[The information requested was not available to the subcommittee at the time of printing.]

Mr. WAXMAN. I take it in looking at title V of our bill you believe it is possible to change the reimbursement system to provide institution additional incentives to train primary care physicians. This is a key part of the legislation in terms of changing the incentives which have been working against family medicine.

[Dr. Chaney nods affirmatively.]

[Dr. Kane nods affirmatively.]

[Dr. Delbanco nods affirmatively.]

Dr. KANE. I would like to emphasize one other part relative to that in my statement, which says when we are in the community, we must stay competitive with community practices. And yet, it is a teaching practice with all the additional costs, supervisory and otherwise, attached to it.

We at this point have no mechanism to get that additional cost of teaching back, and this bill does allow for that.

Dr. DELBANCO. I have provided you with a study we did a few years ago looking at the cost of such a program in the outpatient setting. I think there is a methodology you can now use. There need be more studies. It is very variable, State by State, what is paid for by whom, and for whom. The street corner on which the hospital or the model practice unit happens to be located can make an enormous difference.

But the thing that a hospital or any institution is most frightened of is "soft money"—grant money. If you can change the medicare and medicaid law, the other third parties might well follow suit, and that would make an enormous difference in institutionalizing better care for outpatients, at the same time as better training programs.

Mr. WAXMAN. Since you have worked so extensively in the area of reimbursements, do you see us just increasing the fees paid to physicians who are less well-paid, which, of course, would be very expensive, or do you see it is possible to limit fee increases in some of the areas in which physicians are more highly paid now?

Dr. DELBANCO. I was once quoted by the AMA as saying "I have yet to meet a starving physician," and that has not changed. I don't think doctors are underpaid. The median net income for the office-based physician in 1978 was $68,000, and 30 percent of surgeons and gynecologists made over $100,000 net. They are not at the poverty level.

Today you cannot just add everything on. I do not think you should just pay general doctors more than they are used to, and certainly should not without taking it away from some of the others. What I have been arguing, and I did some work on this in relation to Blue Shield when I was here, is that within medicine we have to change some of the rather crazy reward and incentive systems.

A family doctor testified here 2 years ago that if he drove for 2 hours in the middle of the night to an emergency room and resuscitated a dying patient, he would get about $8 from medicare. On the other hand, if he set a wrist, put a cast on, and it took him 20 minutes in the office, he would get $172. That is a crazy incentive system.

To the degree that economic forces play a part, and it is not an infinite degree and doctors don't think just in terms of money, thank God, but to the degree they do play a part, you are crazy to go into a primary care specialty. If you want to make a lot of money, you become a subspecialist in one of the procedure-oriented, high technology subspecialties.

Mr. **Waxman**. Dr. Chaney, I understand the AAFP supports the continuation of GMENAC. Does the academy feel its concerns have been properly considered by GMENAC, and do you believe the continuation of GMENAC would help you achieve your 25-percent goal?

Dr. **Chaney**. Yes, I think so. If we have representation statutorily on any continuation of GMENAC, and I think we should, I believe that our goals and the needs of health manpower and our views will be felt through that agency.

The original chairman of GMENAC was a member of our organization, Dr. Stelmach, and through that I think we have had input into GMENAC that they would not have had otherwise.

Mr. **Waxman**. Dr. Carter.

Mr. **Carter**. Thank you, Mr. Chairman.

My time is quite limited, but certainly I want to work with you for better legislation in this area. I would like to know if that was a primipara which presented footling.

Dr. **Delbanco**. No, it wasn't, and baby and mother probably would have done fine on its own, as you said. By the way, it will not thrill you to hear that at least at my hospital, which is very "academic," all breech deliveries are done by Caesarian section.

Mr. **Carter**. All breeches?

[Dr. Delbanco nods affirmatively.]

Mr. **Carter**. That is very interesting. One of the most difficult deliveries known to man, I believe, is a single footling and a primipara. I have difficulty with those. Actually, a frank breech is much easier although slower, but that is beside the point.

What factors affect the number of primary care physician training programs at your institutions, gentlemen?

Dr. **Kane**. I think the number is controlled in our institution by the total amount of support that would be available for the aggregate number of residents in training from all disciplines. So finance is part of it.

I think the second part of it is sufficient patients to provide adequate opportunity to learn. But I think the principal difference at our institution is financial.

Mr. **Carter**. You recommend that community-based hospital residents be financed at an equal basis with university-based residents. Is that correct?

Dr. **Kane**. My statement was I did not want to see our community-based programs receive any funding through the grant program strictly through their university affiliation. We would like to keep it independent as it is now.

Mr. **Carter**. Independent as it is now.

Dr. **Kane**. The other thing I would also say is the majority of family physicians trained in this country are not trained in our university centers. They are trained in our community hospital programs.

Mr. **Carter**. And you want to see that funding continued?

Dr. **Kane**. Absolutely. I would also make the statement I want to see departments receive significant support over and above the residency training to allow them to achieve faculty parity with other clinical disciplines in the school.

Mr. **Carter**. I would think most of you are in favor of provisions in title V of H.R. 6802. Is that correct?

[Dr. Kane nods affirmatively.]

[Dr. Delbanco nods affirmatively.]

Mr. **Carter**. Thank you, gentlemen.

Mr. **Waxman**. Thank you very much. We appreciate your being with us.

Our next witness is Dr. Thomas Bartlett, president of the American Association of Universities, on behalf of the AAU, ACE, NASULGC Joint Committee on Health Policy. He will be accompanied by Dr. Robert Clodius, president, National Association of State Universities and Land Grant Colleges; and Dr. Jack Peltason, president of the American Council on Education.

STATEMENT OF THOMAS BARTLETT, PH. D., PRESIDENT (AAU) ALSO ON BEHALF OF JOINT COMMITTEE ON HEALTH POLICY OF THE ASSOCIATION OF AMERICAN UNIVERSITIES; AMERICAN COUNCIL ON EDUCATION; AND NATIONAL ASSOCIATION OF STATE UNIVERSITIES AND LAND-GRANT COLLEGES, ACCOMPANIED BY ROBERT CLODIUS, PH. D., PRESIDENT (NASULGC); AND JACK PELTASON, PRESIDENT (ACE)

Dr. **Bartlett**. Mr. Chairman, my name is Thomas Bartlett. I am president of the Association of American Universities. As you have suggested, I am accompanied by Robert Clodius, who is the president of the National Association of State Universities and Land Grant Colleges; and Dr. Jack Peltason, president of the American Council on Education.

We appear today on behalf of the joint committee on health policy, which is representative of our three associations.

Our associations represent the institutions which provide the training for the overwhelming majority of all health professionals. The joint committee was organized to present a coordinated response to relevant national issues.

For example, health professions education financially is faced with cutbacks in capitation, biomedical research funds that don't keep pace with inflation, drastic decreases in research training funds, discrimination against medical school physicians in reimbursement policies, unrealistic ceilings on payments to teaching hospitals, and inadequate reimbursement of overhead costs.

Federal and State regulations increase costs and reduce operating flexibility. In the face of such pressures, presidents and chancellors lack resources from which they can fill the gaps created. We don't sit before a clean slate. The Federal/university partnership for training health care professionals is decades old.

Federal support to achieve Federal objectives has encouraged health profession schools to expand and take on new tasks. Federal support began and has continued because health profession schools are national resources unusually expensive to operate, and yet they are essential for the attainment of Federal goals.

The university/Federal partnership has created a system remarkably effective and respected throughout the world. It has increased the supply of health manpower of a high quality. It has been a powerful engine for life-serving research. It has improved access for students across economic and cultural barriers, and lately it has increased the emphasis on training primary care physicians.

Curtailment of Federal support would result in cutbacks and deterioration of the quality of our training and/or higher charges to students, with a resultant barrier to access. We are disturbed that the administration bill, H.R. 6800, in both its inadequate provisions for student aid and its lack of any provision for institutional aid, ignores the past and makes no provision for the future.

As for H.R. 6802, we understand that a guiding principle is continuity and we applaud the recognition that health professions programs and institutions are complex and easily damaged by sudden changes in mandates.

I do wish to make one general point about health manpower legislation. Our schools exist to serve several social purposes. While an essential one of these is to increase the supply of primary health care providers, other social goals are also important.

For example, our society supports an extensive biomedical research effort, which is a vital part of our health care system. But the Nation is now developing an increasing shortage of clinical investigators. This shortage of experts to bridge the gap between research and clinical practice should be an explicit Federal concern along with concern for supply of primary health care providers.

Another of our purposes is to maintain access to health professions for students from all backgrounds. If we respond merely by providing larger loans, the resulting high personal debts could determine career choices and insure subsequent high professional charges.

H.R. 6802 continues existing student aid programs, but these may no longer be adequate. Reduced levels of authorization and loan terms which may be unattractive to lenders, as was suggested earlier this morning, suggest that the student aid portion to this legislation could fail and fall short as a means to provide access for less wealthy students.

The joint committee which we represent has not had time yet to review the legislation in depth, and therefore has not been able to adopt a general position on each of the detailed provisions. But we will certainly do so.

Meanwhile, we wish to commend you and your subcommittee for your support of health education programs. We stand ready to assist in your efforts for a reauthorization of new health manpower legislation. Thank you.

[Testimony resumes on p. 382.]

[Joint Committee on Health Policy statement follows:]

AAU
NASULGC

Testimony before the
House
Subcommittee on Health and the Environment
March 24, 1980

by

Thomas A. Bartlett
President
Association of American Universities

Robert Clodius
President
National Association of State
Universities and Land-Grant Colleges

J. W. Peltason
President
American Council on Education

Delivered in behalf of the
AAU/ACE/NASULGC Joint Committee on Health Policy

Association of American Universities, One Dupont Circle, Washington, D.C. 20036 (202) 466-5030
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Mr. Chairman and members of the Subcommittee, I am Thomas Bartlett, President of the Association of American Universities. I am accompanied today by Dr. Robert Clodius, President of the National Association of State Universities and Land Grant Colleges and Dr. Jack Peltason, President of the American Council on Education. We appear today on behalf of the Joint Committee on Health Policy representative of the membership of our three associations. We are grateful for the opportunity to present our views on the critically important topic of federal health manpower legislation.

Let me begin by telling you about the Joint Committee. It has been organized by presidents and chancellors of universities with large commitments to the education of health professionals. These institutions have come together in order to present a coordinated and considered response to a complex series of challenges. The pulls and tugs of various worthy programs and projects sometimes threaten the academic and fiscal integrity, and even the coherence, of our institutions. We have seen the multiple impacts on our institutions of uncoordinated policies of different federal agencies. For example, the health education sector is faced almost simultaneously by cutbacks in capitation, failure of biomedical research funds to keep pace with inflation, decreases in research training funds, discrimination against medical school physicians in reimbursement policies, unrealistic ceilings on payments to teaching hospitals, and inadequate reimbursement of overhead costs on federal projects. At the same time new federal requirements are inexorably increasing administrative costs and reducing our capacity to make our day to day decisions. University presidents and chancellors were and are concerned that they lack the resources to fill in the financial gaps being created. At the same time, they know they must respond without permitting federal intrusion into curricula, courses, admissions decisions, and other aspects essential to the most fundamental purposes of the academic enterprise.

The membership of the Joint Committee is broad, representing institutions which provide training for the overwhelming majority of health professionals from the critically important allied health professions to the most sophisticated biomedical research activity.

In discussing the training of health manpower it is important to remember that we do not start with a clean slate. We have in place a decades-long federal university partnership. The education aspects of health professional schools have been expanded and strengthened with federal support over the last 17 years. A certain mutual dependency has developed, which, while not always good, is a fact. Federal support started and has continued because of the recognition that these schools were national resources, that they were necessary for federal goals, and that they were unusually expensive to operate. The partnership has been successful in creating a system that is the envy of the world.

It has increased the total supply of health manpower of a high quality, improved access across economic and cultural barriers, and increased the training available for primary care physicians--to mention just a few accomplishments. Withdrawal of federal support would result in cutbacks and deterioration in the quality of our training and/or higher costs to students with the resultant barriers to access. The legislation now being developed will be critical for the decade ahead.

I understand that a guiding principle of H.R. 6802 is continuity. We applaud the recognition that universities are complex organizations easily damaged by sudden changes in mandate. However, we are wary lest certain changes in existing law, which at first appear minor, prove to be far-reaching and disruptive.

We believe institutional support should operate in a two-tier manner, a base grant providing subsistence level of institutional support at no less than the level received by institutions in FY '79. This will provide a commitment by the federal government to hold harmless institutions with respect to their previous acceptance of federal mandates. The base grant would allow institutions to maintain teaching facilities in the basic and clinical sciences. It would provide stable funding, enabling institutions to adapt to changing national needs. It would help to insure maintenance of teaching equipment and instruments, library resources, and teaching laboratories, and finally, it would help prevent tuition levels from becoming intolerably burdensome to students.

The second tier would provide particular support to institutions that undertake or continue programs in areas of national priority. This form of support would recognize the importance of diversity in the programs of academic health institutions and would be based on braod categories of national need. Examples of programs supported include incentives to encourage recruitment of students previously disadvantaged groups; incentives to encourage students to enter careers in primary care; incentives to encourage institutions to serve as regional health education resources; and incentives to encourage students to enter careers in teaching and research.

All health professions are struggling desperately to maintain financial integrity. They are disproportionately affected by inflation. Changes in Medicare regulations undermine reimbursement policies. Their endowments are being eroded as they are continuusly tapped to enable institutions to maintain cost controls. In this atmosphere, the first to be discarded are new faculty and innovative programs, precisely that which must be developed today if we are to achieve the national goals that lie behind the legislation before your subcommittee. There is a growing dependency on expanded practice plans of teaching faculty within medical schools. This works as an emergency stopgap, but it already has served as a dangerous incursion n the teaching time and research commitments of this highly specialized faculty in our health professions institutions.

Institutional support should not be predicated upon any single function of complex and diverse institutions. While it may be in the national interest to increase the supply of primary health care providers, there are other equally important goals for health professions institutions. The federal government supports an extensive biomedical research enterprise. The nation is now experiencing an increasing shortage of clinical investigators. The training of the M.D. researcher is in the national interest. Federal concern over any shortage of those experts who bridge the gap between research and clinical practice should be equal to concern over the supply of providers of primary care. In addition, institutional support should be based on factors over which individual institutions have control.

No less important than institutional aid is student aid. High tuition will preclude access to health professions education to all but the very wealthy. High debt may ultimately feed the spiralling health care costs which continue to erode our economy. While private universities are faced with high tuitions which preclude open access to graduate health professions education, public institutions are unable to raise tuition to compensate for erosion in other sources of support.

H.R. 6802 continues existing student aid programs. While a number of these programs have served student needs well, there is concern that they are no longer adequate. In addition, reduced levels of authorization, as well as loan terms which might be unattractive to lenders, increase our concern that the student aid portion of this legislation would fail to provide real access to less wealthy students.

We are disturbed that the Administration bill, in both its provisions for student aid and its lack of any provision for institutional aid ignores the past and makes no provision for the future. The Health Professions Student Loan program provides basic support for many students. The Health Education Assistance Loan program, although appropriate for some students, will not suffice as the only source of student loans. We are disappointed that the Administration chooses to ignore the contributions of institutional support.

Mr. Chairman, we command you and your Subcommittee for your support of health education programs. We stand ready to work with you and your committee to assure reauthorization of health manpower legislation.

Mr. **Waxman**. Thank you for your testimony.

Dr. Bartlett, as I understand what you are suggesting to us, it is to have a two-tier support. One would be special grants, and the other would be capitation. Capitation currently is exchanged for meeting certain national needs. What justification would you have for us to continue capitation without asking that these needs be met either to deal with primary care or other concerns?

Dr. **Bartlett**. Capitation came into existence as a way to encourage health profession schools to grow. That was for 10 years its single purpose. Those health profession schools did grow. They grew dramatically, as was pointed out earlier today. That support for schools that have grown, if now withdrawn, would logically suggest that the schools should contract. They expanded on the assumption that there would be support for a larger size, and yet it seems to me that no one really at this point wishes to make the judgment that our health professions program should grow smaller.

What I am suggesting is that we have to some extent, if you like, worked ourselves out on a limb. And if one eliminates a part of the funding base that got us there, we are, in a sense, sawing off the limb after we are on it.

Subsequent to that initial social objective, which was to expand those programs we have, indeed, begun to add other criteria for capitation, the most important one now being primary health care training. But in 1974, of course, one of the principal concerns was not only primary health care training but also improving the distribution of physicians of various kinds.

We have added purposes, but it doesn't seem to me it can be argued we have eliminated the original basis on which capitation was based. It is a long answer to a short question.

Mr. Waxman. It is a good answer. The original purpose, of course, was to increase the number of physicians. Do you think we have a need in this country to increase the number of physicians?

Dr. Bartlett. I think we have a need not to cut back on the programs that were created through Federal incentives.

Mr. Waxman. Even when the needs might have changed?

Dr. Bartlett. How can I put this? I don't believe that anyone wishes to reduce the size of these programs. So in a sense, saying the needs have ended would be to say that it is no longer necessary to maintain the programs as large as they are. Capitation was given to those programs in order to keep them at the size they now are. It was at that point built in to the budgeting processes of our health professions education programs.

Now, if we take that element out, then something else has to give. In fact, what has been giving, of course, has been a significant increase in the support of the medical schools through practice plans. That has really been what is taking up the slack.

Now, maybe that is desirable. But I think there are very significant arguments as to why we do not wish to shift the financing burden significantly any more than we already have into practice plans.

Dr. Peltason. If I may add one quick comment, there are, I think, legitimate national goals other than just expansion or extending primary care. Those are very important goals. But the joint committee also suggests in that two-tier package, that there are other objectives that are legitimate for Federal support: Increasing the number of minority students, for example.

Mr. Waxman. Would you support keeping those provisions in the legislation dealing with increasing disadvantaged students representation?

[Dr. Bartlett nods affirmatively.]

[Dr. Peltason nods affirmatively.]

Dr. Bartlett. We were also very pleased and gratified that when the two-tiered system was developed, it included also a provision for encouraging the training of clinical investigators, because given the financial incentives for people not to do that, we are going to have to work very hard to counteract the pulls away from our clinical investigator who will stay in the teaching/research profession at lower incomes.

If that function is not fulfilled, then the training of our future physicians is seriously handicapped and our research operation is handicapped. One of the things one hears constantly is that that group of people is diminishing and the attraction to that profession is declining.

Mr. Waxman. I thank you very much for your testimony. It will be helpful for us as we consider this legislation. You have mentioned you will continue to review the legislation in detail. We will look forward to receiving any other comments you might want to bring to us. Thank you.

I would like to now call Dr. C. H. William Ruhe, senior vice president of the American Medical Association, who will be accompanied by Mr. Harry Peterson.

Dr. Ruhe, we are pleased to have you with us today.

STATEMENT OF C. H. WILLIAM RUHE, M.D., SENIOR VICE PRESIDENT, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY BRUCE BLEHART, DEPARTMENT OF LEGISLATION

Dr. **Ruhe**. I am Dr. William Ruhe, a senior vice president of the AMA, and with me is Mr. Bruce Blehart, who is a member of our department of legislation.

We have a fairly long statement, Mr. Chairman, which we will submit for the record. [See p. 387.]

Mr. **Luken** [presiding]. Without objection, it will be received.

Dr. **Ruhe**. In the interest of time, we will summarize an abstract from that statement.

First of all, we are very pleased to have the opportunity to present the views of the AMA on this important legislation. With respect to the general provisions of health manpower legislation, we believe two factors are singularly important for insuring the strength of the educational system.

First, the institutions themselves must have sufficient resources to provide education of high quality. Second, the students who wish to pursue careers in the health professions must have the resources to meet the costs of this education. In general, the AMA believes there should be several types of governmental programs for the financial support of the educational system.

Unrestricted general institutional support has been a valuable investment of public funds and should be continued, although not necessarily linked to capitation. Special project grants should be provided for a variety of purposes related to strengthening the curriculum, community needs and other factors.

Guaranteed loans should be made available for modernization of existing physical facilities, many of which are now badly out of date. Special assistance should be available for schools with serious financial problems.

Substantial financial assistance should be provided for health profession students. This should include a program of guaranteed loans, optional payback provisions, loan forgiveness for services in areas of need, contractual service arrangements such as those in the uniformed services, and grants in aid without obligation for repayment for able but economically disadvantaged students.

The national health service program should be continued as a source of support for students who wish to practice in underserved areas.

Mr. Chairman, I would now like to comment on some of the specific issues addressed by the specific pieces of legislation before this committee. First, construction and modernization funding. H.R. 6800 would repeal all construction assistance for health profession schools. H.R. 6802 would also effectively repeal construction funding since it does not authorize appropriations for construction grants after fiscal year 1980.

However, H.R. 6802 would provide for loan guarantees that would be limited to remodeling, renovating, or alteration of teaching facilities through 1983. The AMA realizes that Government funds to support medical schools through either construction funding or funding for the modernization of existing facilities are necessarily limited.

With limited resources available, we believe it would be more appropriate to commit Federal resources to the modernization and improvement of existing schools.

CAPITATION GRANTS

H.R. 6800 repeals the current program of capitation funding for medical schools. H.R. 6802 continues capitation funding and retitles the program "Institutional Support Grants."

H.R. 6802 recognizes the valuable role of basic institutional support in improving medical education. However, the new conditions for the first year residency positions fail to recognize that an individual qualified in a subspecialty in a primary care area such as general internal medicine or pediatrics is also qualified as a primary care physician.

The fact that the individual physician has taken additional educational training beyond that required for primary care residency does not abrogate the physician's commitment and previous education in his or her chosen field. Furthermore, conditions over which the medical schools have no control, such as the newly graduated physician's choice of residency, should not be a factor in restricting funds to the schools.

The provisions also fail to recognize that many physicians in specialty practice continue to provide substantial amounts of primary care.

FINANCIAL DISTRESS GRANTS

Both H.R. 6800 and H.R. 6802 continue the availability of financial distress grants.

The AMA believes that this program serves a necessary and valuable purpose and should be continued. We urge the Secretary to monitor this program carefully so that institutions work to become financially stable.

PROJECT GRANTS

H.R. 6802 and H.R. 6800 continue special project grants in categories such as family medicine, area health education centers, residency programs, and primary care practice and others.

The AMA views special project grants as a valuable method of strengthening the medical school educational program and furthering medical and other health needs of national or local importance. Health care institutions and medical schools should be allowed to develop programs and apply for grants that would aid in meeting needs which are ascertained as being beneficial to the local area or institutions.

Flexibility in choosing projects is highly desirable in order for the schools to accomplish beneficial goals.

Since the time has run short, Mr. Chairman, I would like to say two additional things. We do continue to support the National Health Service Corps with some concern about the identification of areas of need, and we support the provision of H.R. 6802, which would call for a study of procedures under which the Corps is carried on and under which the Corps personnel are assigned.

For student assistance we are strongly in support of a variety of assistance programs for medical students, and we believe that students entering medical school should have the opportunity to choose among a variety of programs, including those which permit loan forgiveness or repayment of the loans through service.

We would be very glad to respond to any questions the committee may have on any of the matters we have discussed.

[Testimony resumes on p. 408.]

[Dr. Rhue's prepared statement with attachment follows:]

Statement

of the

AMERICAN MEDICAL ASSOCIATION

before the

Subcommittee on Health and Environment
Committee on Interstate and Foreign Commerce
United States House of Representatives

Re: Health Manpower Legislation; H.R. 6800, H.R. 6802

by

C.H. William Ruhe, M.D.

March 24, 1980

Mr. Chairman and Members of the Committee:

My name is C.H. William Ruhe, M.D., and I am a Senior Vice President of the American Medical Association. With me is Bruce Blehart, a member of the AMA Legislative Department. I am pleased to have the opportunity to present the views of the AMA on federal health manpower legislation before this Committee.

In the area of medical education, it is in the best interests of medical schools, government, the medical profession, and especially patients, that the relationship between government and medicine be as constructive as possible. Collectively our paramount concern and goal must be the provision of high quality medical care. The AMA encourages actions promoting this goal.

Support for medical education and health manpower training is a responsibility to be shared by all segments of our society. Federal and state government support is an appropriate activity, and such support can provide a foundation for the maintenance of our strong medical educational system which is the best way to assure that medical and other health services of high quality will be available.

Two factors are singularly important to assuring the strength of the educational system: First, the institutions themselves must have sufficient resources to provide education of high quality; and second, the students who wish to pursue careers in health professions must have the resources to meet the costs of this education. Government support must exist to bridge the gap between the limits of private resources and the total costs of medical education.

General Discussion

Institutional Support

Medical schools should receive support from multiple sources, both nongovernmental and governmental. Governmental funds should be available for a variety of purposes and we recommend that several types of governmental programs be used to provide financial support where it is most needed. Unrestricted general institutional support has been a valuable investment of public funds to improve the quality and availability of medical education and therefore medical care. Since medical schools use these funds according to the specific needs of the schools and the communities they serve, the importance and effectiveness of these funds are much greater than their relatively small size might indicate. Should general institutional support be lost, two immediate results can be anticipated: First, schools would have to seek other sources of funds, possibly through tuition increases; and second, the quality and the availability of medical education would suffer.

General institutional grants should be only one of various mechanisms for medical school support. The amount of these grants, however, need not be large in relation to the school's financial income. Their proportional value is based more on their flexibility in use, as determined by individual schools, than on the absolute amount of funds available. Moreover, such funds, which add to the stability of the medical school, need not be tied to the existing program of "capitation" grants.

A second source of medical school support should be in the form of special project grants. With special project grants each institution may judge whether it can and should participate, based on factors such as curriculum strengthening, community needs, as well as other factors. Also, the government has the option of awarding grants for a variety of activities, including those deemed to be of national or local importance. Since participation is voluntary, each school can choose those grants best suited to its unique characteristics.

Previous health manpower legislation placed emphasis upon the development and construction of medical school facilities. Modernization of existing facilities is now essential if the quality of the educational programs is to be maintained. As one method to meet this goal we encourage a system of government guaranteed loans, along with interest subsidies, as the most effective means of generating funds for modernization from private money markets. Insofar as possible schools should seek private financing for these projects. Government's primary role should be to stimulate the private sector to make needed funds available; however, some schools may be unable to obtain private funds. For these instances we urge that government serve as a lender of last resort, and funds should be available for this purpose.

The AMA also supports special assistance for schools with financial problems that threaten the quality of their programs and even their continued operations. Such assistance, however, should not become a permanent crutch for faltering schools. Rather, it should be geared to overcoming immediate financial hurdles and lead to financial stability. Any school assisted in this manner must be obligated to take all necessary steps to achieve sound financial stability within a reasonable time.

Student Assistance

The costs which students must now bear for their medical education have reached the point where a majority of students must seek substantial financial assistance to begin and continue their training. We are deeply concerned by the financial pressures placed on students, and we firmly believe that access to medical education must not be allowed to become limited on the basis of income. The great strides taken in recent years to make medical education available to various segments of our society should be allowed to continue. We are committed to seeing that financial resources are available to aspiring health professionals.

As one means of assistance, the AMA through its Foundation operates its own loan guarantee program for medical students and resident physicians. Since the inception of this program in 1962 more than $95,000,000 in loans have been guaranteed. Current loans amount to $46,000,000, and in 1979 alone more than $4,000,000 was guaranteed. Our resources, however, are not sufficient to meet an ever growing demand in the face of rising tuition costs. It is essential that government at all levels take steps to assure students continued access to adequate resources. Student assistance must be of the highest priority for government action relative to aid for medical education. It is important that a variety of sources for funds be available to students.

We believe that an effective mechanism for government participation is a program of guaranteed loans. Such a guarantee encourages private lenders to make money available to students and serves to minimize the strain on government resources. The use of guaranteed loans also enhances the ability of students and newly licensed physicians to make intelligent career choices according to their interests and capabilities. While there is pressure to control such choices according to "national needs" as perceived by some, we believe that freedom of choice must be encouraged.

While we heartily endorse the guaranteed loan mechanism, we believe that at the same time additional systems can, and should, be available. For example, contractual service arrangements (between students and resident physicians and organizations such as the armed forces or other governmental services) are one option. Scholarships for those students showing exceptional ability should be encouraged. Furthermore, financial grants-in-aid, without obligations for repayment, should be available for able but economically disadvantaged students. We encourage both the states and the federal government to make these kinds of options available so that students can make choices according to their needs and abilities.

The AMA encourages the continuation and expansion of loan forgiveness programs as an effective means of meeting national needs. Upon the completion of his or her education, a physician should be free to choose to repay a government loan directly, or to participate in a program of service in some needed area in lieu of payment. Loan forgiveness options should be realistic to accomplish their purpose. A strong system of loan repayment through service will greatly assist in meeting the needs for the provision of medical services in areas where they are not available. Service in such areas could be fulfilled by participation in private practice, or under the auspices of a national organization such as the Public Health Service, or the National Health Service Corps (NHSC). This type of program has the principal advantages of providing students the opportunity to select a service obligation after having completed training and of providing communities with young physicians who desire to serve in such areas.

We would also recommend that repayment of student loans be deferrable during the period of medical school training, as well as through residency training where financial limitations might pose a hardship in meeting loan obligations. Consideration should also be given to interest subsidies for a period related to the length of training. In any event loan repayment could be related to the capacity of the individual to repay the principal of the loan, based upon the length of time following completion of medical training.

As a further alternative method of student financing, the NHSC Program serves a valuable role for those students who desire to practice in underserved areas. The AMA supports the continuation of the Corps as a beneficial method of providing medical services in underserved areas. We have actively supported the program through our Project U.S.A., a service designed to place physicians in Corps areas for short periods of time to relieve the assigned physician on a temporary basis. While we continue to support the NHSC, at this time we are concerned about certain aspects of the program, particularly the definition of shortage area.

Nurse Training

The AMA supports continued federal assistance to programs of basic nurse training in order to meet the nation's nursing needs. Federal assistance should be provided to the training institution as well as to the student.

Specific Legislative Issues

Mr. Chairman, at this time we would like to comment on some of the specific issues addressed by the proposals before the Committee. Because the bills were only recently introduced, we have not completed our analysis of all the complex issues presented in the legislation. These preliminary comments will focus on institutional support for medical education (construction funds, capitation grants, financial distress grants, and special project grants); the National Health Service Corps (NHSC); student assistance; alien foreign medical graduates; the Graduate Medical Education National Advisory Committee; and Medicare and Medicaid amendments.

Construction and Modernization Funding

H.R. 6800 would repeal all construction assistance for health profession schools. The Secretary of Health and Human Services would still be required to monitor compliance with conditions associated with previously authorized construction grants, loans, and loan guarantees. Your bill, Mr. Chairman, (H.R. 6302) would also effectively repeal construction funding since it does not authorize appropriations for construction grants after fiscal year 1980. Under this bill the Secretary would also be able to monitor compliance on existing loans or grants. Loans or grants which were made would not be tied to further enrollment increases. H.R. 6802 would provide for loan guarantees that would be limited to remodeling, renovating or alteration of teaching facilities through 1983. Both H.R. 6800 and H.R. 6802 would repeal start-up assistance for schools of medicine.

The AMA realizes that government funds to support medical schools through either construction funding or funding for the modernization of existing facilities are necessarily limited.

While previous health manpower legislation did place emphasis upon developing and construction new medical school facilities, current circumstances demand instead new emphasis on the modernization of many existing facilities if the quality of the educational programs is to be maintained.

With limited resources available for federal support for construction, we believe that it would be more appropriate to commit federal resources to the improvement of existing schools. H.R. 6802 authorizes loan guarantees for remodeling, renovation, and alteration of teaching facilities, and would have the effect of promoting private funds for needed modernization of existing facilities.

Capitation Grants

H.R. 6800 repeals the current program of capitation funding for medical schools; H.R. 6802 continues capitation funding and retitles the program "institutional support grants." Under H.R. 6802, schools applying for institutional support grants would have to give the Secretary prior assurances that they will expend an equal amount of funds from non-federal sources for the same purpose, additionally, the current requirements that a specific percentage of filled first-year residency positions in direct or affiliated residency programs be in primary care would be reduced by five percentage points. Subspecialties would not be considered primary care residencies under this bill. H.R. 6802 would decrease authorized funding for institutional support grants from the current $139,000,000 in fiscal year 1980 to $70,000,000, $77,000,000 and $85,000,000 for fiscal years 1981-1983.

H.R. 6802 recognizes the valuable role of basic institutional support in improving medical education. However, the new conditions for the first year residency positions fail to recognize that na individual qualified in a subspecialty in a primary care area such as general internal medicine or pediatrics is also qualified as a primary care physician. The fact that the individual physician has taken a year or more of additional educational training beyond that required for primary care residency does not abrogate the physician's commitment and previous education in his or her chosen field. By failing to recognize these subspecialties this legislation could have a chilling effect on their further development. Furthermore, conditions over which the medical schools have no control, such as the newly graduated physician's choice of residency, should not be a factor in restricting funds to the schools. The provisions also fail to recognize that a physician in specialty practice continues to provide primary care.

As stated above, the primary benefit and value of capitation funds or institutional support grants stem from their flexibility. While funds from non-federal sources are commonly used for the same purposes, a school's option to fund a program totally through the use of institutional support grants should not be eliminated.

While we believe that the imposition of conditions upon the receipt of institutional support is undesirable, we are pleased that H.R. 6802 recognizes this important funding source.

Financial Distress Grants

Both H.R. 6800 and H.R. 6802 continue the availability of financial distress grants.

The AMA believes that this program serves a necessary and valuable purpose and should be continued. We urge the Secretary to monitor this program carefully so that institutions work to become financially stable. Institutions that receive assistance through this program should be obligated to take reasonable steps to become financially stable. The AMA has recognized the value of a financial distress grant program, and has developed draft legislation on this subject for consideration by the Congress (copy attached). This draft proposal, now introduced as H.R. 6887, would extend and increase financial distress grants with an emphasis on schools with substantial minority enrollment. We urge your careful consideration of this bill.

Project Grants

H.R. 6800 revises the special project grant provision within the health manpower law by eliminating list of specific examples which is contained in Section 788 (d) of the Public Health Service Act. H.R. 6802 and H.R. 6800 continue special project grants in categories such as family medicine, Area Health Education Centers, residency programs in primary care practice, and others.

The AMA views special project grants as a valuable method of strengthening the medical school educational program and furthering medical and other health needs of national or local importance. Health care institutions and medical schools should be allowed to develop programs and apply for grants that would aid in meeting needs which are ascertained as being beneficial to the local area or insititutions. Flexibility in choosing projects is highly desirable in order for the schools to accomplish beneficial goals.

The identification of several significant goals to be achieved through project grant funding can aid in achieving national needs and objectives.

National Health Service Corps (NHSC)

Both H.R. 6800 and H.R. 6802 maintain the NHSC and increase authorized funding for the Corps operational programs. Although, funds authorized for

NHSC scholarships would be decreased from the fiscal year 1980 level of $200,000,000 to $93,500,000 is fiscal year 1981, $80,000,000 was the amount actually appropriated for fiscal year 1980. H.R. 6800 contains a program which would authorize the Secretary to enter into cooperative agreements with the states to develop a plan for reducing any geographic maldistribution of health professionals, and to develop a state health professionals placement program. If the Secretary approves the state plan, Corps personnel will be assigned to that state and priority would be given to states which provide substantial financial support for health professionals placement programs.

Under H.R. 6802 the Secretary would be authorized to conduct studies to demonstrate improvements in assignment of Corps personnel and improvement in health care delivery through coordination with state and local governments and other entities with an expertise in planning, development, and operation of centers for the delivery of primary care. H.R. 6802 requires a demonstration program where the Secretary would assign Corps personnel to work within a program which has been developed by a state. Corps members who work in such a state program would be classified as members of the Corps, but not as an officer or an employee of the Corps.

H.R. 6802 also contains a provision authorizing the Secretary to enter into contracts with or make grants to public and private non-profit entities to develop and run programs which are designed to prepare individuals obligated under the scholarhsip program to provide health services in manpower shortage areas. Additionally, recipients of NHSC scholarships who choose to work in private practice will be obligated to accept Medicare fee "assignment" under Title XVIII.

As we have indicated above, the AMA supports the NHSC program. However, aspects of the program should be carefully evaluated to determine whether its objectives are being appropriately met. For example, the definition of "shortage area" should be examined closely. Recent figures indicate a significant disparity in the number of persons reported as living in medically underserved areas. It should also be noted that during the eight-year existence of the Corps, the number of shortage areas has increased and the purported number of persons living in shortage areas continues to grow. H.R. 6802 should be commended for recognizing this fact and authorizing studies to investigate improvements which can be made in assigning Corps personneland in the delivery of health care through coordination with state and local entities. Both H.R. 6800 and H.R. 6802 recognize the advantages in greater local involvement in assigning NHSC personnel. This is only a first step to localizing placement and utilization of Corps personnel. Emphasis should be placed on community involvement, including increased participation of local professional societies in assignments of personnel. Such involvement would help the program to achieve the objective of establishing long-term private practice in shortage areas.

The provision of H.R. 6802 requiring that physicians who select the private practice option must accept the Medicare fee (under Title XVIII) "assignment" or face possible mandatory service in the NHSC would, in our opinion, be counterproductive. This provision would mandate the physician to accept as total payment for services an amount that has been determined by the Health Care Financing Administration as the "reasonable charge" for services. We are concerned that a requirement for acceptance of Medicare "assignments" would discourage the desire to establish the private practice mode, when, in fact, encouragement should be provided. Incentives for long-term private practice are needed. Mandatory acceptance of Medicare fee "assignments" in the NHSC program would be short-sighted and counterproductive.

Student Assistance

Both H.R. 6800 and H.R. 6802 extend the exceptional financial need loan and insured loans to graduate students in health professions schools for three years. The statutory 12% limit on interest currently contained in the guaranteed loan program is repealed under H.R. 6800, while H.R. 6802 fails to provide for this necessary adjustment. Students eligible for a guaranteed loan under H.R. 6802 will also be eligible to receive a loan under the Higher Education Act of 1965, and interest and principal due on the guaranteed loan will be deferred until the completion of training.

H.R. 6802 continues the health professions direct student loan program through fiscal year 1983, but at slightly lower authorization levels. This program does not receive continued funding under H.R. 6800.

As witnessed by the significant amount of money guaranteed over the years by the AMA through its Foundation, the AMA has long recognized the necessity for continued student assistance. H.R. 6802 contains many commendable provisions relating to student assistance, but in light of the current economic climate the interest ceiling on the guaranteed student loan program must be repealed.

Students entering medical school should have the opportunity to apply for financial assistance from a variety of programs. Noting the success of the guaranteed loan program operated by the AMA through its Foundation, we feel that programs of this type should be encouraged. Loan forgiveness, i.e. repayment through service, should also be available at a realistic rate to encourage recently graduated physicians to serve in areas of need.

Foreign Medical Graduates

H.R. 6800 and H.R. 6802 recognize the fact that existing immigration requirements may prevent alien foreign medical graduates, as exchange visitors enrolled in graduate medical education programs, from completing most programs in graduate medical education. H.R. 6800 would address this problem by waiving the special immigration requirements for medical exchange visitors through calender year 1983. H.R. 6802 would allow an alien foreign medical graduate to participate in a graduate medical education program for the lesser of seven years or the time typically required to complete the program.

The AMA has recognized the need to alter the immigration laws to reflect the necessary time for alien foreign medical graduates to complete residency programs. To this end the AMA had developed draft legislation (copy attached) which would alter the Immigration act along the lines now being proposed in H.R. 6802.

Graduate Medical Education National Advisory Committee (GMENAC)

H.R. 6802 would statutorily establish GMENAC, and direct it to report annually to the Secretary and make recommendations on: 1) the need for and supply of physicians in various medical specialties; 2) with respect to the geographic distribution of physicians, factors affecting a physician's choice of graduate medical training and location of practice; 3) the effect that the rate of reimbursement for services and the availability of financial support for graduate medical education has on the selection of a specialty or subspecialty; 4) the proportion of health services which are provided by resident physicians; and 5) other matters which relate to graduate medical education. GMENAC will also recommend specific goals to the Secretary for the distribution of physicians by medical specialties and subspecialties and the number of graduate medical education positions that should be available in each of those specialties and subspecialties.

Following inactment of P.L. 94-484, which authorized the Secretary of HEW to collect data relating to health personnel, he created GMENAC on an ad hoc basis to advise him relative to some of the matters enumerated above and now proposed to be crystallized in statue. To date, GMENAC has only released a tentative report, the final report originally being due in April, 1980. GMENAC has now requested an extension on this reporting date to September, 1980, and this request has been granted.

The AMA has actively been involved in the GMENAC study, and our former President, Tom Nesbitt, M.D., is currently a member of GMENAC.

We believe it is premature to consider establishment of GMENAC as a standing committee. Such consideration should not be undertaken prior to release of the final GMENAC report.

Medicare and Medicaid Amendments Relating to Primary Care Residency Programs

Under H.R. 6802 a hospital which has an accredited residency program in family medicine, primary internal medicine, or primary pediatrics may elect to have a resident physician's services provided to out-patients treated, for the purposes of Medicare reimbursement, as physician's services under Part B. These services would be classified as "primary care residency training facility services." If the hospital makes such an election, its reasonable costs (under Part A) would not include those costs which are normally allocable to the furnishing of resident physician services. Medicare would pay 80% of the costs which are reasonable and related to the furnishing of services, and Medicaid would pay 100% of such costs. The hospital could charge the Medicare patient no more than the normal Medicare deductible or coinsurance.

This provision of H.R. 6802 would have the effect of creating two classes of resident physicians: "primary care" residents, and "non-primary care" residents. This dichotomy in eligibility under the proposed mechanism fails to recognize the fact that residents in general, and not just those residents identified as residents in "family medicine, primary internal medicine, or primary pediatrics (as determined by the Secretary in regulations)", provide out-patient services. These services are a valuable element of a physician's education. This proposal, by creating an incentive for only certain residents to deliver out-patient care, would have a long-term negative effect, and the quality of medical education and medical care will suffer.

This provision would also have a deleterious impact on graduate medical education. It would create incentive for health care institutions to discontinue "non-primary care" residencies. Furthermore, we are concerned with the authority given to the Secretary to define new residency classifications.

We recommend that Title V of H.R. 6802, as proposed, not be adopted.

Conclusion

Mr. Chairman, and Members of the Committee, I would like to thank you again for having this opportunity to present the views of the AMA on health manpower issues and legislation. We would be pleased to work with the Committee to aid in the development of legislation continuing appropriate federal assistance for health manpower. Actions taken today on health manpower questions will undoubtedly impact on tomorrow and years to come. We urge the Committee to review these issues with care, and to consider not only the need to answer today's problems but the need to guarantee the quality of medical care for the future.

At this time I will be pleased to respond to questions which the Committee may have.

96th Congress
1st Session

DRAFT

Bill No. _____

IN THE (SENATE) (HOUSE) OF THE UNITED STATES

Date __________

_________ of _____ introduced the following bill;
which was read twice and referred
to the ______________ Committee

A BILL

To amend the Public Health Service Act to provide federal assistance to health professions schools in serious financial distress.

Be it enacted by the Senate and the House of Representatives of the United States of American in Congress assembled,

Section 1. The Public Health Service Act is amended by

(a) deleting Section 788(b)

(b) redesignating subsections (c), (d), (e), (f) and (g) as "(b)", "(c)", "(d)", "(e)" and "(f)" respectively,

(c) amending subsection (d)(2), as redesignated above, to read as follows: "(2) From the sums authorized to be appropriated under paragraph (1) not more than $5,000,000 may be obligated or expended for purposes of subsection (a).", and

(d) by adding a new subsection (g) as follows:

"(g)(1) The Secretary may make grants to schools of medicine, osteopathy, dentistry or public health which are in serious financial distress for the purposes of assisting in--

"(A) meeting the costs of operation of any such school of medicine, osteopathy, dentistry and public health,

"(B) meeting accreditation requirements, if they have a special need to be assisted in meeting such requirements,

"(C) carrying out appropriate operational, managerial, and financial reforms on the basis of information obtained in a comprehensive cost analysis study or on the basis of other relevant information,

"(D) meeting the costs of maintaining the quality of their educational programs, or

"(E) meeting the costs of strengthening their academic resources and capabilities.

"(2) Any grant under this subsection may be made upon such terms and conditions as the Secretary determines to be reasonable and necessary, including requirements that the school agree--

"(A) to disclose any financial information or data deemed by the Secretary to be necessary to determine the sources or causes of that school's financial distress,

"(B) to conduct a comprehensive cost analysis study, and

"(C) to carry out appropriate operational, managerial and financial reforms as the Secretary may require, except that the Secretary shall not require changes in the educational component of the school's program.

"(3) A recipient of a grant under this subsection must provide assurances satisfactory to the Secretary that the applicant will expend in carrying out its function as a school of medicine, osteopathy, dentistry or public health, as the case may be, during each fiscal year for which such grant is awarded an amount of funds (other than funds for construction, as determined by the Secretary) from non-federal sources which is at least as great as the average amount of funds expended by such applicant for such training in the two years preceding the year in which the grant is awarded.

"(4) The Secretary shall determine the amount of such grants based on criteria published in accordance with Section 553 of the Administrative Procedure Act. The Secretary shall give special consideration to applications for grants from schools of medicine, osteopathy, dentistry or public health having significant enrollments of students from ethnic or racial minorities or from low income families.

"(5) The Secretary may provide to any school eligible for a grant under this subsection technical assistance to enable the school to conduct a comprehensive cost analysis study of its operations, to identify operational inefficiencies, and to develop or carry out appropriate operational, managerial and financial reforms.

"(6) Notwithstanding any other provision of law, the Secretary may award grants under this subsection of such duration as will best meet the financial needs of the school receiving such grant. In order to award grants of duration longer than one year, the Secretary may obligate funds for such grants for use in a fiscal year in advance of the enactment of appropriations for that year, provided that, if the total funds appropriated for this subsection for a particular fiscal year are not sufficient to meet fully the amounts obligated for that year by the Secretary under grants awarded under this subsection, the amount to be received by each school for that fiscal year shall be an amount that bears the same ratio to the amount previously obligated for that school for that year as the total of the amounts appropriated for that fiscal year bears to the total amount that would be required to make awards to schools for that fiscal year.

"(7) There are hereby authorized to be appropriated for purposes of this subsection $25,000,000 for the fiscal year ending September 30, 1981 and for each of the four succeeding fiscal years."

96th Congress
1st Session

DRAFT

Bill No. _____

IN THE (SENATE)(HOUSE) OF THE UNITED STATES

Date _________

_________ of _____ introduced the following bill:
which was read twice and referred
to the _______________ Committee

A BILL

To amend the Immigration and Nationality Act relating to foreign medical graduates.

Be it enacted by the Senate and the House of Representatives of the United States of America in Congress assembled,

Section 1. Section 212(j)(1)(D) of the Immigration and Nationality Act (8 U.S.C. 1182(j)(1)(D)) is amended to read as follows:

"(D) The duration of the alien's participation in the program for which he or she is coming to the United States is limited to the time necessary to permit such alien to complete the graduate medical training program designated by such alien; provided, that the time deemed necessary for completion of a graduate medical training program shall be determined by the Director, International Communication Agency, or his delegate, on the basis of the published requirements of the accredited program of graduate medical education in a recognized medical specialty in which the alien seeks specialized education and training; and provided, further, that, with the approval of the Director, International Communication Agency, or his delegate, such alien may change his or her designation of program no more than once subsequent to his or her admission to the United States and no later than two years after such admission, if, but only if, the government of the country of the alien's nationality or last residence has provided the certification required by subparagraph (C) of this subsection as to such alien's redesignated program. Any alien engaged in such a graduate medical training program in the United States on the effective date of this Act shall be deemed for purposes of this subparagraph to have been admitted to the United States on that date."

Mr. LUKEN. Thank you, Dr. Ruhe.

First I would like to congratulate you, from what we have heard, at least, about the AMA's own loan guarantee program, which operates for medical students and residents. Are there any particular insights you have obtained from that experience as to how we might best consider addressing student aid issues?

Dr. RUHE. Thank you, Mr. Luken. That program has been operating successfully now for over 15 years, and we have learned a number of things from it. The total amount of dollars guaranteed now in loans is very close to $100 million over that period of time. I think it has been a very effective bulwark against students having to default on their careers and being able to continue in medicine.

What we have learned from it is that the guaranteed loan system does work and we would recommend it as an important type of program to continue.

We have also learned that in the current inflationary period, with interest rates rising so rapidly, it is difficult to get many banks to take on these kinds of loans these days. It is interesting that one of the provisions of H.R. 6800 would be to remove the 12-percent ceiling on loans, whereas 6802 does not call for this removal.

I think we would favor the removal simply because we believe it is unrealistic these days to expect banks to grant loans at 12-percent figures. One might pass the legislation and find there is no money available.

The other option, of course, which could be considered to help this out, is some subsidy of the interest rates to permit a 12-percent ceiling as far as the students are concerned and then a Federal subsidy for the difference.

The problem with that is that at the rate at which interest rates are growing, it implies almost an open-ended commitment on the part of the Government and would be a difficult thing to administer, I expect, for that reason.

Mr. LUKEN. Then you think the 12-percent limit on the Hill loan program should be removed.

Dr. RUHE. Yes, I think so, simply to be realistic about what conditions are today.

Mr. LUKEN. Of course, we may have problems with the Congress in any of these areas these days, the retrenchment. The general loan program for college students, I think, is going to be in trouble, or at least it will be questioned. Although they are very worthy programs. They are going to have problems in these austerity days.

Dr. **Ruhe**. These are difficult times. We are all aware of that, and everyone is anxious to have fiscal restraints. At the same time, we do recognize the growing cost of professional education. Particularly, medical schools faced with rising costs are raising their tuitions, and it is not unusual now for a medical student completing his study to have $40,000 or $50,000 indebtedness.

If present trends continue, that level of indebtedness may be much higher, $70,000 or $80,000 by the completion of the training. That is a staggering load. We are obviously concerned about the impact. The knowledge that such indebtedness will be assumed over a long period of time is going to discourage a lot of people from low- or middle-income families from pursuing professional careers, and I think that would be very unfortunate.

We certainly would not like to see any change in the balance of the income levels of the families of medical students as a result of the costs driving some people out of the market. It would seem that the only hope to avoid that is some kind of combination of loan opportunities with subsidized interest rates, and perhaps a variation of the payback provisions so that the payback can be graduated over the period of time the individual is in practice.

These are difficult problems.

Mr. **Luken**. Let me ask you this, Dr. Ruhe, if you are going to express an opinion with reference to H.R. 6802 and the requirement there that NHSC scholarship obligees who choose the private practice option must accept medicare patients on assignment.

Dr. **Ruhe**. We understand the reason for that provision, but we really think it is unwise. What we ought to be looking for are incentives to students in the National Health Service Corps to enter private practice in the discharge of their obligations, the hope being that having entered into private practice in a given area of need, they will be encouraged to stay in that area of need.

And to the extent that the requirement of acceptance of medicare assignment is a negative incentive, to that extent it is likely to discourage permanent location in an area of need. So we think that is unwise. It is an attempt to do something else by this provision of the legislation, and we feel it is not in order.

Anything which serves as a disincentive is probably not a good thing to do.

Mr. **Luken**. Just one more question. Could you outline for the subcommittee just how the position of the AMA relating to the foreign medical graduates differs from that of H.R. 6802?

Dr. **Ruhe**. I think I will have to confer. I am not sure it is different.

Mr. **Blehart**. It is very similar. A copy of the AMA's provision is attached to our statement as a draft. It is virtually identical. The differences of the program are in the opportunity to complete residence training.

Mr. **Luken**. In the length of time on FMG's, you urged it be in effect as long as it takes rather than the a 7-year limitation, I believe. Go ahead.

Dr. **Ruhe**. We did have a bill which was introduced to this effect, and it is virtually identical to H.R. 6802. There may be a little difference in the length of time, but I don't think it is a practically significant difference.

Mr. **Luken**. That is fine. You indicate that medical schools have little influence on the number and type of residencies with which they have a formal relationship. Why is this? Who does establish the number and types of residencies related to medical institutions?

Dr. **Ruhe**. Let me answer the second question first. The numbers and types of residency programs are established largely by the institutions which offer those programs. It is the collective summation of the totals in each field which determines what is offered. So there is no formal prescription of total numbers, types or location of residency programs today.

We believe, frankly, that that is the way it ought to be and that that is the best way for the future. We believe this provides more flexibility, more opportunities. We do not really favor restriction of educational opportunities. And we think that it is possible to make changes in the balance or mix of graduate education through encouragement, incentive, and exhortation.

As a matter of fact, I think history bears us out very well on this matter. The primary care movement is really fairly long in history, and the medical profession was already strongly involved in attempting to develop new programs for family practice and incentives to go into primary care back in the 1960's.

In 1973, AMA published a formal policy position recommending that 50 percent of graduates enter residency training in primary care. At that time, it was only 35 percent. Two years later, the coordinating council on medical education made a similar recommendation.

By the time the health manpower legislation actually tied capitation grants to that index of primary care residencies, it had already occurred. The 50-percent level had been achieved before the law even was passed.

In this case I think evidence of need in the community, demand for that kind of service by patients, and recognition of that fact by physicians and their organizations led to encouragement of medical students and medical institutions to emphasize more strongly programs in primary care.

The present situation is one in which we have a pretty good balance. The schools themselves cannot guarantee what their graduates are going to do. They can provide emphasis in their own undergraduate programs on certain types of educational opportunities. As you know, most schools now, have under special project grants or special legislation, developed primary care units or family practice departments or things of this sort.

This has led to a considerable change in the posture of students and their attitude toward their future careers. The school can point the student in a certain direction, but the school has no control over the student once the student graduates. And the choice of specialty at the beginning or even more at the completion or end of the residency program is certainly within the individual prerogative of the individual students, as we think it ought to be.

Frankly, any presumption that by determining the mix of residents one can guarantee their function in later practice is, we think, also a kind of delusion. What the physician does in the community is determined more by the needs of that community and the demands patients make on the individual, than it is upon what the past education has been.

We do believe strongly in having a substantial number of graduates provided with a broad base of education in primary care. One of the things which disturbs us about H.R. 6802 is that it would, in a sense, decide that if a student after 3 years of internal medicine decided to take a fourth year in rheumatology or cardiology, that student would then be scratched from the list as being in primary care.

Consequently, the school would lose credit for having had that individual as one of its primary care graduates. The fact is that the individual subspecialty year in no way detracts from the ability of that physician to provide primary care. We know from direct observation and many recent studies that persons who are, in fact, engaged in consultant work deliver a substantial amount of primary care, many of them 70 or 80 percent of their practice.

We think that attempts to prescribe too closely the future practice habits through the residency training program prescriptions are doomed to failure. They are not likely to work and are unwise because they put unnecessary restrictions on both the institutions and the graduates.

Mr. **Luken**. Thank you. That is all I have. Your testimony will be received into the record. The written testimony and your responses have been exceedingly helpful.

Dr. **Ruhe**. Thank you very much, Mr. Luken.

Mr. **Luken**. Thank you for coming and responding to these questions.

Is there anyone else in the room who is expecting to testify? [There was a hand.]

Mr. **Luken**. You are?

Dr. **Gibley**. Dr. Gibley.

Mr. **Luken**. Is there anyone else?

Dr. **Melby**. Dr. Melby.

Mr. **Luken**. Dr. Gibley and Dr. Melby, you were to be part of a panel to testify later. If you would like to go on now, just the two of you, that would be fine with us. We can then take the others when they arrive.

We appreciate your being willing to do that.

Dr. **Melby**. We appreciate the opportunity.

Mr. **Luken**. Dr. Melby is first on our list.

STATEMENTS OF EDWARD C. MELBY, D.V.M., CHAIRMAN, COUNCIL OF DEANS, ASSOCIATION OF AMERICAN VETERINARY MEDICAL COLLEGES; AND CHARLES W. GIBLEY, JR., PH. D., ON BEHALF OF AMERICAN ASSOCIATION OF COLLEGES OF PODIATRIC MEDICINE

Dr. **Melby**. Mr. Chairman and members of the subcommittee, we appreciate this opportunity to express the needs of veterinary medical colleges for continuing Federal financial help.

We would like to submit our statement for the record and I will comment on the present status of veterinary medical education and how H.R. 6802 could provide an effective means of Federal financial support.

Mr. **Luken**. Dr. Melby, you are a veterinarian.

Dr. **Melby**. That is correct.

Mr. **Luken**. With the Association of American Veterinary Medical Colleges.

Dr. **Melby**. That is correct.

Mr. **Luken**. And you have submitted a statement, and that will be received, without objection, into the record.

You may proceed any way you see fit, either to read it or perhaps to summarize it or to comment in any way you want.

Dr. **Melby**. Thank you. I thought I would summarize it and be brief, if I may. [See p. 414.]

Mr. **Luken**. Fine.

Dr. **Melby**. Veterinary medicine is a biomedical science of great breadth and its members provide a wide range of health services, including prevention, control, and treatment of diseases in food producing, companion, and recreational animals.

Veterinarians are among those best equipped to deal with the complex interrelationships among human beings, animals, and the environment. Comparative medicine the interface between animal and human medicine is vital to advances to understanding and preventing disease. Reduction in the quality of education would impair a vital natural resource affecting the food supply, health advances through biomedical research, and the control of diseases of man and animals.

Currently there are about 7,200 students now enrolled in 24 colleges and schools of veterinary medicine. About 1,850 new veterinarians will be graduated this year. The cost of veterinary medical education ranks among the highest in the health professions, far beyond the amount that can be recovered from tuition or other usual sources of college income.

Twenty-one of the veterinary medical colleges are in State universities, and three in private universities which receive substantial State support. And these States represent less than half the total of the 50 U.S. States. They cannot be expected to carry the burden of financing the Nation's cost of veterinary medical education.

To make it possible for the existing institutions to fulfill the regional and national responsibilities to open the profession's doors equally to all qualified students and to insure that the profession benefits from the broadest possible base of good students, Federal sharing in the cost of veterinary medical education is absolutely essential. H.R. 6802, with some changes, would provide a basis for appropriate Federal participation.

A new health manpower authorization should continue the following features for veterinary education:

One, institutional support based upon student enrollment to accomplished specified national goals: H.R. 6802 would authorize about $750 per student per year, and with changes, it would be effective. H.R. 6800 would not.

Student financial aid through scholarship and loan programs, both of which would obligate certain professional services in the national interest: H.R. 6802 provides the basis for this, whereas H.R. 6800 does not.

Financial assistance and construction and renovation of facilities: Neither H.R. 6802 or H.R. 6800 provides appropriate assistance for this purpose.

Financial incentives to attract minority students: Neither H.R. 6802 nor H.R. 6800 would provide effective stimuli for minority recruitment, retention and education in veterinary medicine.

Financial support of special projects to improve the quality of education: Neither H.R. 6802 nor 6800 would accomplish this purpose.

Institutional financial distress grants: While both H.R. 6802 and H.R. 6800 would provide a basis for this, it would appear that H.R. 6800 would be the most effective in providing a lasting remedy for deficit spending.

Dr. Carter's bill, with an amendment to improve the VOPP schools, would also be effective for this purpose.

Finally, financial assistance in the startup of veterinary medical schools. H.R. 6802 would be effective, while H.R. 6800 provides nothing for that purpose.

We urge the subcommittee to accept our recommendations for changes in H.R. 6802 as presented for the record, and we do appreciate the opportunity to present our views. We would be pleased to respond to any questions you may have concerning the testimony.

[Testimony resumes on p. 421.]

[Dr. Melby's prepared statement follows:]

STATEMENT OF EDWARD C. MELBY, D.V.M., CAHIRMAN, COUNCIL OF DEANS,
ASSOCIATION OF AMERICAN VETERINARY MEDICAL COLLEGES

Mr. Chairman and Members of the Subcommittee, the Association of American Veterinary Medical Colleges appreciates this opportunity to express its views regarding continued federal financial participation in health professions education. I am Edward C. Melby, Chairman of the Council of Deans of the Association of American Veterinary Medical Colleges and Dean of the New York State College of Veterinary Medicine at Cornell University. I speak today for the Association of American Veterinary Medical Colleges.

I wish to describe the current status of veterinary medical education and provide our association's comments on the bills before the subcommittee. At the conclusion of this testimony I have outlined the goals of our association for health manpower legislation. That portion contains some ideas for alternative or additional provisions which are not included in the bills.

A crossroads, perhaps a crisis, in veterinary medical education is upon us now. Demands for veterinarians and severe limitations on sources of income for veterinary medical schools are putting vital programs in jeopardy.

In the past few decades, startling changes have occurred in the veterinary medical profession. While the original and most obvious service, the delivery of direct health care to animals and the relationship of that service to food supplies and the nation's economy, remains a basic and vital function it is but one part of a larger responsibility. Thousands of veterinarians work for governmental agencies at all levels, helping to implement regulations designed to assure that only safe, wholesome animal products are marketed for human consumption. Others are involved in public health programs controlling such direct hazards to human health as transmissible animal diseases and dangers arising from toxins and environmental pollutants. Comparative medicine, that area of study which deals with the interface between animal and human medicine and is vital to advances in understanding and preventing disease, requires investigators trained in schools of veterinary medicine. If those on the front lines of veterinary medical activity are to have the knowledge and tools to perform effectively, research in the laboratories and in the field must be relentless and must be pursued by highly trained professionals.

Veterinary medicine is a biomedical science of such breadth that its members are now among those best equipped to deal effectively with the complex interrelationships among human beings, animals, and the environment. If society is to continue to benefit from advances in veterinary medicine, there must be no lapse in the quality of those trained to pursue it. Currently about 7,200 students are enrolled in twenty-four colleges and schools of veterinary medicine in the United States. About 1,850 new veterinarians will be graduated this year. Clearly, any significant reduction in the quality of training would impair a vital national resource. Nevertheless, several factors are threatening to do just that, foremost among them the financial squeeze.

The cost of veterinary medical education ranks among the highest in the health professions, far beyond the amount that can be recovered from tuition or other usual sources of college income. Twenty-one of the veterinary medical colleges are in state universities, and these states cannot be expected to continue to finance the major part of the nation's costs for veterinary medical education. Like schools devoted to training physicians, veterinary medical colleges maintain a high ratio of faculty to students, particularly in the clinical aspects of training; veterinary schools face high costs in recruiting and maintaining high-quality faculties; they must provide expensive laboratories and equipment for teaching the full range of biomedical sciences; and they must provide those vital arenas of instruction, modern teaching hospitals.

Unlike their counterparts in human medicine, those responsible for training veterinarians must prepare their students to deal with complex health problems of not one but many species. They must do this without access to some major sources of income available to medical schools. Most significant for animal health care, there are no third-party payer systems available to owners of animals requiring medical care. This results in severely limiting the service income of veterinary medical teaching hospitals. Income in such hospitals rarely provides more than half the needed support.

With costs of veterinary medical education approaching $20,000 per year of training, it would be folly to presume that the students can carry the financial burden of their education. While physicians are often seen as able to command high incomes and therefore repay large educational debts, the situation for veterinarians is quite different. Starting salaries average about $16,000 and have remained at about that level over several years.

The diminishing federal financial support of recent years and rapidly rising costs have increased the burden on the state governments and veterinary medical students. Current public concern over levels of state spending inhibits sufficient expansion of state appropriattions for veterinary medical education. To attempt to close the income-cost gap by further limiting the enrollment of out-of-state students would be tempting but shortsighted. Because of the geographic locations of the institutions, many states would be underserved, and entire regions of the country would be shortchanged.

To correct the present deficiencies and make it possible for the existing institutions to fulfill their regional responsibilities, to open the profession's doors equally to all qualified students, to insure that the profession benefits from the broadest possible base of good applicants, federal sharing in the cost of veterinary medical education is absolutely essential. The unique role of the veterinary medical profession and veterinary medical institutions in the national health system necessitates adequate and equitable federal financial support of veterinary medical education.

In most respects, we believe that the present law is an efficient tool for achieving the national priorities in veterinary medicine. Therefore, we strongly support the basic intent of H.R. 6802 for it indicates the desire to continue the federal partnership in health professions education. We think that continued federal participation is essential in veterinary medical education, and H.R. 6802, with changes which we recommend, would provide a basis for that participation.

Institutional support grants have proven to be a very effective means of stimulating performance in accord with national goals. Institutional support grants provide a stable funding source for the schools which is critical for rational utilization of funds provided by both state and federal governments. Such grants should provide potential funding of approximately 10% of the cost of education. This indicates the need for an authorization considerably higher than presently provided for in H.R. 6802. We recommend an authorization for an amount which would provide $2000 per student per year in schools of veterinary medicine.

We are in full support of the retroactive elimination of enrollment increases required for construction grants since these increases will result in undue financial burdens on several schools.

We also appreciate and support the extension of the Health Professions Student Loan Program. That program provides a loan source at interest rates which make loans reasonably repayable by young health professionals with modest incomes, as is the case with young veterinarians. The opportunities for loan forgiveness through service in underserved areas provide highly cost-effective means of addressing the needs of medically underserved areas. Veterinary students have eagerly participated in this program, and we encourage the subcommittee to emphasize this program as a major facet of a new health manpower law.

In contrast, the National Health Service Corps (NHSC) scholarship program is practically an unknown quantity in veterinary medicine. Despite the large numbers of students and enormous sums of money that have been involved in the NHSC scholarship program over the years, only four scholarships have been awarded to veterinary students, and this was done only during the current academic year. We believe that the "private practice" option under the NHSC scholarship program is particularly well-suited to veterinarians. We support the removal of the paternalistic requirement that shortage-area private practice can be approved only if the practice would generate an income comparable to Corps salaries.

The Administration's proposal, H.R. 6800, would constitute a de facto withdrawal of the federal government from health professions educational assistance. This attitude is very short-sighted and unfair to students and the states which support veterinary education. We have concluded that H.R. 6800 is beyond redemption and should be disregarded in its entirety.

Moving away from the specific bills before the subcommittee, we would like to outline our association's goals for health professions education legislation. A number of our recommendations are already contained in H.R. 6802, and we urge you to consider that bill as the foundation upon which to build an effective health manpower program. We recommend that new legislation contain the following features:

(1) Institutional support based upon student enrollment to accomplish specified national goals.

(2) Student financial aid through scholarship and loan programs, both of which could obligate certain professional service in the national interest.

(3) Financial assistance in construction and renovation of educational facilities.

(4) Financial incentives to attract minority students and assist in offsetting the costs of retaining them in the professional education programs.

(5) Financial support for certain special projects directed to the improvement of the quality of professional education and preparation for specialized careers critical to national goals.

(6) Institutional financial distress grants restructured to provide opportunities and motivation to move out of a deficit spending situation.

(7) Financial assistance in the initial period of start-up of new veterinary medical schools with preference given to those serving multi-state and regional needs.

Institutional Support Grants

An amount of $2,000 per student (10% of the annual cost of education per student) enrolled in the professional education program should be authorized for annual institutional support grants to schools and colleges of veterinary medicine which perform in the national interest, upon satisfaction of one of the following criteria.

(1) At least 20% of the enrollment of full-time, first-year students in the school is comprised of students who are residents of states in which there are no veterinary medical schools currently graduating students; or

(2) The school expands, or plans to expand within 12 months, its clinical educational resources by one of the following or comparable measures: (a) a satellite clinical facility to improve and amplify its clinical education programs; (b) a new clinical specialty service with at least two appropriately educated and experienced faculty members; (c) a clinical facility to provide continuous emergency care services; or

(3) The school increases by at least 25%, or plans to so increase within one year, the enrollment of post-doctoral students in the specialties of pathology, toxicology, or laboratory animal medicine, or in disciplines essential for careers in veterinary education and research.

Justification of Institutional Support Grants for the Specified Purposes

There are now twenty-four veterinary medical colleges in twenty-three states. Twenty-one are state-supported institutions, and three are components of private universities, in which case some state financial support is available.

Since the twenty-three states provide the basic financial support of these schools, there is particular need to stimulate multi-state and regional educational opportunities through federal sharing of approximately 10% of the cost of education.

Veterinary medical colleges need additional financial resources to provide educational opportunities in the clinical specialty services and to provide facilities and services which will improve the entire clinical education program.

There is a very significant shortage of veterinary pathologists, toxicologists and laboratory animal medicine specialists to serve the requirements for evaluating health impacts of potentially toxic, carcinogenic and mutagenic agents, particularly the health impacts of such agents in model animals. There is also a shortage of qualified veterinarians for academic positions in teaching and research.

Student Financial Aid

A student financial aid program, including scholarships and loan programs, is proposed as follows:

1. Health Professions Student Loans

   A program of federally subsidized low interest loans should be continued and expanded. Such a program should include deferral of repayment obligations for up to five years of post-doctoral education and interest charges should not be the responsibility of the borrower until the professional education and any post-doctoral education are completed. Service in a designated underserved area should qualify as a loan repayment equivalent of $10,000 per year of service.

2. Exceptional Financial Need Scholarships

   A program of scholarships for students with exceptional financial need should be continued and expanded. Such a program should provide partial financial support during the first year of approximately 50% of the costs of education and maintenance, and a similar amount for each succeeding year of the professional educational program.

3. National Health Service Corps Scholarships

   A new National Health Service Corps Scholarship authorization should clearly indicate the intent of the Congress to include veterinary medical students in the scholarship program and veterinarians in the National Health Service Corps service programs. At least 50 scholarships should be awarded to veterinary medical students annually and 50 entry level National Health Service Corps positions should be held for veterinarians in each year of a new authority.

Justification of Student Financial Aid

Since the income potential of veterinarians is not high, certainly not comparable to the income potential of physicians, student aid should be structured to the realistic ability of the young professional person to repay either by service or in money.

Veterinarians could provide valuable clinical veterinary medical, preventive medical, and public health services in the National Health Service Corps, but the opportunity has not been offered. To date no veterinarians have served in the NHSC. Veterinarians would add a dynamic new dimension to the present health care teams of many community health care centers and would improve the economic base of many rural areas.

A loan program with relatively low interest rates should be continued to permit students to enter the veterinary medical profession when family or individual financial resources are inadequate to meet educational costs. Without such a program, many students of low and medium income families will have to give up goals of veterinary medical careers since veterinary medical salaries are inadequate to repay large loans at high interest rates.

Scholarships for exceptionally financially needy students are necessary to offer such students an opportunity for a veterinary medical education, but the program should be restructured to permit the student to continue through the professional program partially supported by the scholarship. The current program of one year of full support results in attracting the student for one year and then "dumping" the student into the hands of the high interest loan market or possibly forcing the student to drop out of school.

Financial Assistance Grants for Start-Up of New Institutions

A program similar to that authorized by P.L. 94-484 should be continued to assist those schools now in development to attain a fully-operational, quality program. The new authority should permit completion of commitments made under P.L. 94-484 to veterinary medical schools. It also should permit new awards to be made to developing schools, particularly those serving multi-state needs, which have, on the effective date of the new authority, a "statement of reasonable assurance" by the recognized accrediting agency.

These developing educational programs have been planned and construction funds have been appropriated on the belief that federal start-up assistance would be available for beginning faculty recruitment, purchasing expensive movable equipment, purchasing autotutorial resources, and beginning an appropriate library collection. Without such start-up support, these programs may have insufficient resources to provide a quality education.

Financial Assistance for Construction and Renovation of Facilities

Authority should be continued for the construction and renovation of educational facilities. Such authority should require matching of federal funds by at least 20% non-federal funds.

Increasing enrollments should not be a requirement of a construction or renovation grant authority, and requirements for increased enrollments applied to grants under P.L. 94-484 should be rescinded as provided in H.R. 6802.

The facilities of several veterinary medical schools are inadequate for contemporary veterinary medical education and should be replaced or renovated. New facilities such as satellite clinical centers are needed by many of the schools to provide a sufficient range of clinical experiences.

Without the assistance of federal funds for these purposes, the states will not be able to meet the needs for adequate facilities, and without them some institutions will provide inadequate, poor quality education. Eventually some may lose accreditation as a result of inferior educational facilities.

Minority Student Enrollment Incentives

A new program for improving minority participation in veterinary education should be authorized. Since minority students may come from disadvantaged educational backgrounds, special programs designed to retain such students in the professional educational programs should be encouraged. Nothing will be gained through a program which attracts minority students unless it also provides incentives and resources to retain them through the program to graduation.

An appropriate authority for veterinary medical education would provide $10,000 per minority student year of education.

Special Projects for Educational Quality Improvement

A program of grants should be authorized to support and stimulate the improvement of educational quality and for innovative efforts to enhance educational experiences.

Projects eligible for such grant support should include:

1. Improvement of clinical instruction by the addition of new clinical services and facilities.
2. Development or expansion of programs for post-doctoral education in the currently under-supplied specialties of pathology, toxicology and laboratory animal medicine or for academic careers in teaching, research and service.
3. Enhancement of educational programs through the addition of satellite facilities and rural health team services or the improvement of education in health care delivery and animal and human nutrition.

Grants to Aid Schools in Financial Distress

Financial distress grants authorized by P.L. 94-484 should be continued, but the program should be revised so that incentives would be provided to terminate deficit spending. Financial distress grants have been a vital factor in maintaining one of the veterinary medical colleges. That one must have further support, and others may need it. The present system of grant eligibility justification which requires evidence of continued deficit spending should be changed. Part of any continuing justification should be based on the presence of a plan of financial recovery and termination of the deficit spending situation.

We urge the subcommittee to accept our recommendations for changes in H.R. 6802 and make appropriate additions to the bill so that it will effectively continue the federal partnership with the states in veterinary medical education. On behalf of the Association of American Veterinary Medical Colleges, I thank the subcommittee for the opportunity to present our views.

Mr. LUKEN. Dr. Melby, you suggest in your prepared testimony that financial assistance should be available for startup of new institutions. How many schools of veterinary medicine do you believe would fill the need of such assistance?

Dr. MELBY. At the present time, there has, first of all, been a tremendous demand for entrance into our schools. Within recent years, it has been three times more difficult to obtain admission to a veterinary medical school than to a medical school. I think that is partially the reflection of the number of schools as well as the interest in biology and other areas.

There are several States, in response to this tremendous pressure for admission, who are in various stages of development. I think it would be important for those schools, having made that commitment in thinking there would be the additional resources from the Federal Government, to continue that commitment of those schools now in that stage of development.

Beyond that, we see no need for further expansion.

Mr. LUKEN. Section 788, the assistance to disadvantaged students. If that were expanded and funds channeled to the health professions school, would that help you with increasing minority enrollments?

Dr. MELBY. I think so, sir. We have a very difficult time attracting minority students. We are competing, as you know, with other health profession schools. There is a problem of lack of numbers of minority students now in veterinary medicine. The role model is not there. There are a variety of other things.

I can tell you it is a headhunting expedition for us to try to attract, get them and retain them.

Mr. LUKEN. All right, Dr. Melby. Thank you.

If you want to stay around for a moment, we may want to discuss it a little bit with Dr. Gibley, who is in another health profession. Dr. Gibley is with the podiatrists. Is that right, Dr. Gibley?

Dr. GIBLEY. I am not with the podiatrists but I am with the Association of Colleges of Podiatric Medicine. My background is a Ph. D. in anatomy and I am dean of one of the colleges.

Mr. LUKEN. Which one is that?

Dr. GIBLEY. Pennsylvania College of Podiatric Medicine.

Mr. LUKEN. In Philadelphia?

Dr. GIBLEY. In Philadelphia.

Mr. **Luken**. It seems like I have seen you there once before.

Dr. **Gibley**. Yes, I believe you were there in June.

Mr. **Luken**. All right, Dr. Gibley, proceed.

STATEMENT OF CHARLES W. GIBLEY, JR.,

Dr. **Gibley**. The association represents the five independent colleges of podiatric medicine which educate this Nation's entire supply of podiatrists. I am pleased to have the opportunity to comment on both Congressmen Waxman's and Staggers' proposals for reshaping our national policy regarding health manpower.

The challenges facing podiatry in the 1980's are unique among the health professions. Unlike our colleagues in the other major health disciplines, we are part of a profession that remains critically undermanned. Additionally, podiatry remains the most seriously maldistributed of all the health professions.

Finally, podiatry continues to suffer because many people do not recognize that we are a primary care discipline. Podiatry is a primary care profession. A podiatrist provides comprehensive care for a significant portion of the human anatomy, the lower extremities.

The podiatrist has a high index of suspicion for those systemic diseases which are manifested in the foot: for example, diabetes mellitus, peripheral vascular disease, arthritis, uremia, and venereal disease.

Let me also point out that the current emphasis in our health system on a cost-effective ambulatory care brings the podiatrist to an even more central position in this system since a podiatrist's training is focused largely on assuring the ability to ambulate.

Indeed, the vast majority of podiatric care is provided in ambulatory settings. With the impetus of Federal aid, the five colleges of podiatric medicine have dramatically increased enrollments since the mid-1960's. In 1966, there were 700 podiatric medical students enrolled; today there are over 2,500, a threefold increase. In 1966, the colleges awarded degrees to 135 individuals and in 1979 to 575 individuals.

Additionally, each college now has a newly constructed or completely renovated physical plant. Despite these successes, due in large part to past manpower health bills, much remains to be done.

According to the Department of HEW, podiatry remains the most critically undermanned and the most seriously maldistributed of all the major health professions.

Mr. **Luken**. In that connection, do you agree or disagree with HEW's projected supply and requirements for your profession in 1990?

Dr. **Gibley**. We agree with it and are pleased to find out that an outside agency has come up with the same conclusions we have had over the years. It was nice to see that another agency which cannot be accused of self-serving come up with those figures.

Mr. **Luken**. All right, proceed.

Dr. **Gibley**. At current graduation rates, HEW has projected a 30-percent shortfall of practicing podiatrists in this country by 1990. With each of our schools currently educating maximum numbers of podiatrists, there is no chance of eliminating this shortfall without a Federal commitment to assist in expanding our operations.

We simply have nowhere else to turn for institutional support. Already, our students are carrying a larger share, 50 percent of the cost of their education, than any other health profession's students. Similarly, the States in which our schools are located cannot be expected to provide major support for our schools. The States understandably view the graduates of our five schools as national or regional, and not State resources.

We are greatly disturbed by the paucity of institutional support found in Mr. Staggers' bill, introduced on behalf of the administration. The termination of capitation grants without any attempt to provide alternative means of support would work a very severe hardship on our schools.

Mr. Waxman's institutional support grants would be very helpful in maintaining our ongoing operations. These grants are critical to the continued strength of our colleges. While we wish the proposal offered more generous institutional support, its authorizations are reasonable, given national fiscal concerns. Thus we support the provisions of section 770 of H.R. 6802.

Yet, as I pointed out earlier, an increase in the number of graduates of each of our schools is necessary if the foot care needs of our Nation are to be met in the coming decade. Increases are not possible without Federal financial support in addition to the institutional support offered by the Waxman bill.

Therefore, we propose that the committee institute a special project authority designed to alleviate both the shortage and maldistribution problems in podiatry through regional efforts by the colleges of podiatric medicine. Under the proposal, colleges would receive Federal funds to institute an intensive effort to recruit students from underserved areas from across the country.

In addition, the colleges would guarantee that each such student would receive the equivalent of 1½ years of clinical training in an underserved area. This effort could be undertaken with $3,000 per recruited student year in special projects grant funds. We estimate the total cost to the Federal Government at approximately $1 million.

Student assistance programs are critically important to the students of podiatric medicine. As I mentioned earlier, our students pay a larger share of the total cost of their training than do other health profession students. Half of the annual $12,000 cost of podiatric medical education is borne by the student.

It is not surprising that students of podiatric medicine are far more involved in the high interest of the health education assistance program than are students of any other profession.

Let me try to summarize the last couple of pages of this since I have gone over the time limit. We certainly support the National Health Service Corps and scholarship program for podiatry students. That is one of the ways you can help us graduate enough students and return them to underserved areas.

[Testimony resumes on p. 432.]

[Dr. Gibley's prepared statement follows:]

STATEMENT OF CHARLES W. GIBLEY, JR., PH. D.,
AMERICAN ASSOCIATION OF COLLEGES OF PODIATRIC MEDICINE

INTRODUCTION

Good afternoon. I am Dr. Charles Gibley, Dean of the Pennsylvania College of Podiatric Medicine and immediate past president of the American Association of Colleges of Podiatric Medicine. The Association represents the five independent colleges of podiatric medicine which educate this nation's entire supply of podiatrists.

I am pleased to have the opportunity to comment on both Congressman Waxman's and Congressman Stagger's proposals for reshaping our national policy regarding health manpower.

The challenges facing podiatry in the 1980's are unique among the health professions. Unlike our colleagues in the other major health disciplines, we are part of a profession that remains critically undermanned. Additionally, podiatry remains the most seriously maldistributed of all the health professions. Finally, podiatry continues to suffer because many people do not recognize that we are a primary care discipline.

PRIMARY CARE

Podiatry is a primary care profession. A podiatrist provides comprehensive primary care for a specific portion of the human anatomy -- the lower extremity. The podiatrist has a high index of suspicion for those systemic diseases which are manifested in the foot, e.g., diabetes mellitis, peripheral vascular disease, arthritis, uremia and syphilis. Let me also point out that the current emphasis in our health care system on cost-effective ambulatory care brings the podiatrist into an even more central position in this system, since the podiatrist's training is focused largely on assuring the ability to ambulate. Indeed, the vast majority of podiatric care is provided in ambulatory settings.

INSTITUTIONAL ASSISTANCE

With the impetus of federal aid, the five colleges of podiatric medicine have dramatically increased enrollments since the mid-1960's. In 1966, there were 700 podiatric medical students enrolled; today there are over 2500. In 1966, the colleges awarded degrees to 135 individuals and in 1979 to 575 individuals.

Additionally, each college now has a newly constructed or completely renovated physical plant.

Despite these successes, much remains to be done.

According to the Department of HEW, podiatry remains the most critically undermanned and the most seriously maldistributed of all the major health professions. (2 → At current graduation rates, HEW has projected a 30 percent shortfall of practicing podiatrists in this country by 1990. With each of our schools currently educating maximum numbers of podiatrists, there is no chance of eliminating this shortfall without a federal commitment to assist in expanding our operations.

We simply have nowhere else to turn for institutional support. Already, our students are carrying a larger share (50 percent) of the cost of their education that any other health profession's students. Similarly, the states in which our schools are located cannot be expected to provide major support for our schools. The states understandably view the graduates of our five schools as national or regional, and not state resources.

We are greatly disturbed by the paucity of institutional support found in Mr. Stagger's bill, introduced on behalf of the Administration. The termination of capitation grants without any attempt to provide alternative means of support would work a very severe hardship on our schools.

Mr. Waxman's institutional support grants would be very helpful in maintaining our ongoing operations. These grants are critical to the continued strength of our colleges. While we wish the proposal offered more generous institutional support, its authorizations are reasonable, given national fiscal concerns. Thus we support the provisions of Sec. 770 of H.R. 6802.

Yet, as I pointed out earlier, an increase in the number of graduates of each of our schools is necessary if the foot care needs of our nation are to be met in the coming decade. Increases are not possible without Federal financial support in addition to the institutional support offered by the Waxman bill. Therefore, we propose that the Committee institute a special project authority designed to alleviate both the shortage and maldistribution problems in podiatry through regional efforts by the colleges of podiatric medicine. Under the proposal, colleges would receive Federal funds to institute an intensive effort to recruit students from underserved areas from across the country. In addition, the colleges would guarantee that each such student would receive the equivalent of one and one-half years of clinical training in an underserved area. This effort could be undertaken with $3,000 per recruited student year in special projects grant funds. We estimate the total cost to the federal government at approximately $1 million. (3)

We believe that this type of special project would have an immediate and positive impact on both the shortage and maldistribution problems in podiatry. The program would provide our colleges with needed incentives and resources for increasing enrollment. Further, by focusing recruitment and clinical training efforts in underserved areas, we would be more certain of attracting significant numbers of students with an orientation toward eventual practice in such areas. We will submit to the Subcommittee detailed specifications for this special project proposal in the near future.

AREA HEALTH EDUCATION CENTERS

We are distressed that both the Waxman and Administration proposals contemplate no growth in AHEC funding. The AHEC program potentially is very helpful in exposing health profession students to an interdisciplinary approach to education which will serve them well in later practice. Podiatry has long been interested in participating more fully in the AHEC program and we propose that the law be amended to increase our opportunities to participate. Specifically, we suggest that Section 781(c)(4) of the Public Health Service Act be amended to allow colleges of podiatric medicine, which are within a reasonable distance of an Area Health Education Center, to have reasonable opportunities to actively participate in the programs of the AHEC.

STUDENT ASSISTANCE

Student assistance programs are critically important to students of podiatric medicine. As I mentioned earlier, our students pay a far larger share of the total cost of their training than do the other health professions' students. Half of the annual $12,000 cost of podiatric medical education is borne by the student. It is not surprising that students of podiatric medicine are far more involved in the high interest Health Education Assistance Loan (HEAL) Program than are students of any other profession.

We are grateful to note the support, in both of the bills under discussion, for the National Health Service Corps and its scholarship program. Students of podiatric medicine have only recently begun participating in the NHSC scholarship program. With proper recruitment and orientation efforts, we believe that this program will be successful in providing quality health care in underserved areas. We are very excited about participating in this program and we request that the Committee legislatively earmark a certain percentage of scholarships for podiatry, based on relative shortages vis a vis the other primary care medical professions.

We also support the emphasis in these bills on facilitating entry into the health professions of minority students. Efforts on the part of podiatry to recruit and retain minority students have met with only mixed success. Representation of minorities in podiatric medical schools increased from less than one percent at the beginning of the 1970's, to 7 percent today. Despite some gains, much more needs to be done in this area and we welcome the resources to accomplish our goals of full and fair representation of all groups in podiatry.

We cannot protest too strongly the deletion of the student loan program proposed by the Administration bill. Even now, our students are incurring education debts, which often require payback of as much as $170,000 over a 15 year period. This amounts to more than $900 per month in loan repayments. Such enormous debts necessarily translate into high patient fees, and general escalation of costs throughout the health care system. Health care cost inflation must be attacked at its roots and enormous student indebtedness ranks as one of the most stubborn roots. This is no time to cut off the means for keeping student indebtedness within manageable limits. We support Chairman Waxman's proposal to extend the student loan program and suggest that funding be as full as possible, for saving dollars at this level will cost the system far more when huge education loans become due a few years from now.

TRANSFER OF PODIATRY TO THE DIVISION OF MEDICINE

We reiterate that the profession of podiatry, if properly utilized, can ease our country's serious shortage of primary care medical professionals. Consistent with the new found appreciation of podiatry's primary care role, our professional programs were administratively shifted, effective September 5, 1978, from the HEW Bureau of Health Manpower's Division of Associated Health Professions to the Division of Medicine. The profession supported this administrative transfer based on the similarities among podiatry and the traditional MOD professions in the areas of educational background, of license to diagnose illnesses, prescribe drugs, perform surgery, and to admit and refer patients. We believe that this transfer will facilitate a very constructive dialogue among the primary care medical professions.

We strongly believe that any comprehensive renewal of the health manpower authorizations should take note of this administrative transfer in all appropriate instances. We urge you to amend the statue, as necessary, to legislatively recognize the transfer of podiatry to the Division of Medicine. We will be happy to assist the Committee in any appropriate way in facilitating this important objective.

This concludes my prepared remarks. I will be happy to answer whatever questions the Committee members may have.

Mr. LUKEN. Thank you. It is not a question of your having gone over. We are running into a whole passel of votes here and will have to leave. I have another 30 seconds or so.

Would each of you tell us what percent of your operating funds capitation represents at this time?

Dr. MELBY. Of course, this would vary from school to school, but in our school we are talking about probably 4 percent.

Dr. GIBLEY. We are talking about 15 percent, I think, across our colleges.

Dr. MELBY. I would point out one thing. It may seem like a small amount of money, but it is about the only source of money that has any flexibility for programatic support.

Mr. LUKEN. And what percentage of your students are receiving aid?

Dr. MELBY. Nearly 85 percent, at the moment. The average student getting out of our school today has an indebtedness of $30,000 to $40,000. This is increasing. Our cost of education is about $20,000 per student per year.

Dr. GIBLEY. Ninety percent of our students do.

Mr. LUKEN. I thank both of you for coming on behalf of the veterinary and podiatry professions.

We are sorry we have to abbreviate it.

You have both been very helpful. We will recess. You need not come back unless you want to listen.

We will recess this session until 2 o'clock.

Dr. GIBLEY. Thank you very much for the opportunity.

[Whereupon, at 12:45 p.m., the hearing was recessed.]

AFTER RECESS

[The subcommittee reconvened at 2 p.m., Hon. Henry A. Waxman, chairman, presiding.]

Mr. WAXMAN. The meeting will come to order.

I would like to welcome to the panel Michael Gemmell, executive director, Association of Schools of Public Health; Gary Filerman, president of the Association of University Programs and Health Administration; and Dr. Kent W. Peterson, executive vice president of the American College of Preventative Medicine.

We are pleased to have you here today. We have your prepared statements, which will be made a part of the record in their entirety. We would like you to summarize, if you would, around 5 minutes, so that we will have an opportunity for questions and answers.

Proceed any way you wish.

STATEMENTS BY MICHAEL K. GEMMELL, EXECUTIVE DIRECTOR, ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH; GARY L. FILERMAN, PH. D., PRESIDENT, ASSOCIATION OF UNIVERSITY PROGRAMS IN HEALTH ADMINISTRATION; AND KENT W. PETERSON, M.D., EXECUTIVE VICE PRESIDENT, AMERICAN COLLEGE OF PREVENTIVE MEDICINE

Mr. GEMMELL. Thank you, Mr. Chairman.

I am Michael K. Gemmell, executive director of the Association of Schools of Public Health. We appreciate the opportunity to present our views on Federal support for graduate public health training in general and on H.R. 6802, the "Health Professions Educational Assistance and Nurse Training Amendments of 1980," in particular. [See p. 435.]

The deans of the U.S. schools of public health applaud the members for holding hearings on extension and revision of Public Law 94-484 and look forward to working with you in developing a bill that seeks to:

One. Provide an adequate supply of health personnel to work in aras of national need such as disease prevention, health promotion, health administration, policy and management, environmental and occupational health, epidemiology, biostatistics, nutrition, maternal and child health, among others.

Two. Increase the supply of public health students and graduates of schools of public health from underrepresented minority groups.

Three. Promote the development of curriculum in national priority public health disciplines.

Four. Implement the national health goals outlined in the recent Surgeon General's report, "Healthy People."

Five. Support programs training medical personnel in areas of preventive medicine and dentistry.

Six. Upgrade the management skills of executives in health policy and management programs.

Seven. Support studies to evaluate the present health manpower production system, determine the cost of educating and training community and public health personnel and to identify functional and geographic areas in which there are shortages of public health workers.

Eight. Provide institutional support to schools of public health to enable the training of public health specialists in manpower shortage areas.

We believe, Mr. Chairman, that H.R. 6802 addresses these points, especially the last one. The bill provides basic financial institutional support for costs incurred by the schools of public health in providing comprehensive training of personnel charged with the responsibility for carrying out Federal programs, such as HSA's, HMO's, Clean Air Act, Toxic Substances Act, FDA programs, maternal and child health programs, senior citizen and nutrition programs, Clean Water Act, PSRO's, among others, and new Federal initiatives outlined, again, in "Healthy People."

The schools of public health are training individuals needed to carry out the goals of the Surgeon General's report. The thesis of the report is that "further improvements in the health of the American people can and will be achieved, not alone through increased medical care and greater health expenditures, but through a renewed national commitment to efforts designed to prevent disease and to promote health."

Mr. Chairman, the schools of public health are in the business of training men and women for public service. Our graduates work primarily in the public sector in the areas of health promotion and disease prevention. They represent the basic resource pool from which Federal, State, and local health and environmental agencies draw their manpower needs.

Graduates also work and teach in university settings. Industry relies heavily on the schools to train their employees involved in industrial hygiene, occupational safety and health, environmental toxicology, among others. The breakdown is as follows: 50 percent of graduates in a single given year go into Federal, State, or local government service, 32 percent work for either nonprofit community health agencies or universities, and 12 percent work for industry and other proprietary organizations.

The schools no longer primarily train professionals for State and local government agencies. In response to a demand for new types of health workers and a broader concept of public health, the schools have made major efforts to train students in health administration, environmental and occupational health, health care management, nutrition, and similar specialties in national priority areas.

Let me skip over some of these points, Mr. Chairman, and summarize the rest of my statement.

In closing, Mr. Chairman, we must make one final point. The schools of public health are heavily dependent on Federal assistance to increase the capacity of the schools to respond to emerging National, State, and local public health needs and to enable them to offer comprehensive graduate training in critical areas which are unsupported by other funding sources, including State governments and their parent universities.

What is the justification for Federal support to schools of public health? Public health schools train personnel for public service. The Federal Government has a direct interest in assuring that an adequate supply of public health personnel is trained in quality institutions to manage and operate the health delivery system in the national interest.

Federal support to our schools, Mr. Chairman, is an investment at the front end of the health care system. Our graduates and researchers will not only help prevent illness but will help slow down the rapidly escalating costs of medical care.

The deans thank you for giving us the opportunity to present our views. We request that our detailed statement describing further the goals and objectives of the schools of public health and our specific comments on H.R. 6802 and the administration's proposal be incorporated into today's record.

Thank you, Mr. Chairman.

[Testimony resumes on p. 447.]

[Mr. Gemmell's prepared statement follows:]

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STATEMENT OF THE ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH TO THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT OF THE HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE ON H.R. 6802, THE HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE AND NURSE TRAINING AMENDMENTS OF 1980, MARCH 24, 1980, WASHINGTON, D.C.

The Association of Schools of Public Health (ASPH)*, which represents all of the twenty-one U.S. Schools of Public Health, appreciates this opportunity to present its views on H.R. 6802, the "Health Professions Educational Assistance and Nurse Training Amendments of 1980" and the Administration's health manpower proposal. H.R. 6802 is a comprehensive legislative proposal which seeks to accomplish a number of very important goals.

The purpose of this statement is two-fold: one is to make the Congress and this Committee aware of the major training and financial problems facing Schools of Public Health today; and two is to clearly spell out the ASPH position on the Federal role in public health professions educational assistance programs.

Public health deals with the protection and improvement of community health by organized community effort. Public health activities are essentially a public or government responsibility. The services of public health agencies are not reimbursable on a fee-for-service basis as are personal health services. Rather than treating the symptoms of disease in one person, public health is concerned with discovering how a disease occurs, in halting its spread and in organizing programs for those who have been or may be affected by it in a community, a state or a nation. The goal in theory and in practice is to discover the source of ill health and to reduce or eliminate it at the earliest point. As a public responsibility such preventive activities have been largely supported by public funds.

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*ASPH is the only national organization representing the Deans, faculty and students of the twenty-one Schools of Public Health. The Schools represent the primary educational system that trains personnel needed to operate our Nation's public health, disease prevention and health promotion programs. ASPH's principal purpose is to promote and improve the education and training of professional public health personnel.

Public health measures have been successful in controlling communicable diseases as a major cause of death in the United States. While these measures should continue to prevent a resurgence, today the major public health problems in this country involve the causes and control of chronic diseases such as cancer and heart disease; the control or elimination of environmental health hazards; and the provision of equal access to quality health care at reasonable costs.

In recent years Congress has addressed these problems through significant legislation dealing with environmental health, disease prevention and planning, evaluation and management of the health care delivery system. Such legislation has created growing manpower needs in public health. The demand is expected to continue and increase as new programs to improve the quality of life and reduce health care costs are enacted.

Few studies have been conducted on the impact of the new legislative initiatives on the demand for public health manpower. A study conducted in 1973, prior to the enactment of the health planning law and the current emphasis on cost containment, showed a short fall in every category of professional public health manpower:

U.S. Estimated Supply of and Requirements for Selected Categories of Professional Public Health Manpower*

	Professionals with masters level training or higher			
	Base Year Supply (1970 unless specified)	1980 Supply, assuming		Possible 1980 Requirements
Occupational Category		Constant School Output	Reduced School Output	
Environmental Health	2,200	4,300	3,800	5,000
Epidemiology	1,000	1,800	1,500	2,000
Health Education	2,000	3,600	3,100	6,000
Health Services Administration	8,500	18,200	15,300	25,200
Health Statistics	1,100	1,700	1,500	2,500
Maternal Health, Family Planning & Child Health	800	1,800	1,500	2,000
Mental Health	200	400	350	1,100
Public Health Dentistry	300	550	500	550
Public Health Nursing	2,457	5,200	4,500	5,700
Public Health Nutrition	1,000	1,800	1,500	2,600
Public Health Veterinary Medicine	200	350	300	550

*Department of Health Administration, School of Public Health, University of North Carolina. Professional Health Manpower for Community Health Programs. Chapel Hill, North Carolina, 1973.

The Schools of Public Health are the major manpower training resources available to meet the increasing demand for highly trained and competent personnel in the public health field.

Federal health professional manpower policy has focused almost exclusively on physicians and has based policy decisions affecting other health professions on conclusions relating to physicians. For example, studies have shown that there may be a substantial oversupply of physicians around 1990. Based on this finding the President's FY 1981 budget request assumes an oversupply of all health professionals and consequently targets its request for health professions education programs at minimizing the future oversupply of health professionals. As suggested by the chart, the available evidence indicates an undersupply of public heatlh personnel. Also the recent Surgeon General's report (Healthy People) found that there is a need for prevention manpower especially in the fields of epidemiology, biostatistics, health administration, environmental health, occupational safety and health, nutrition, among others. Further, a December 1979 HEW report to Congress on community and public health personnel also called for increased federal support to programs training professionals in these priority public health areas.

The Schools of Public Health* have been educating professionals in the techniques of public health practice, health preservation, health promotion and disease prevention and control since the first decades of the twentieth century. Some Schools of Public Health had their beginnings in university schools of medicine; others were conceived from the outset as autonomous units within their parent institutions. Today there are twenty-one fully accredited Schools of Public Health in the United States, 7 at private and 14 at public universities.

Schools of Public Health are distinct from other health professions schools in a number of ways. They are oriented to the community and prevention rather than to the individual and cure. They train people in a value system that is equalitarian and public service oriented. They train persons to be need oriented rather than demand oriented. They teach techniques of need response and how to view the "community as a patient". Students are prepared for community teamwork and administration rather than private practice. To solve community health problems the typical graduate works on a team in organized community action, deals with administrative problems and must understand group behavior as well as health care techniques.

Located in 17 states and Puerto Rico, the 21 accredited Schools of Public Health train students from every state in the nation. The Schools have a combined enrollment of over 7,000 students and a faculty in excess of 1,700.** Graduate education in the 21 Schools is organized around a number of major specialties.

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*University of Alabama in Birmingham, University of California-Berkeley, University of California-Los Angeles, Columbia University, Harvard University, University of Hawaii, University of Illinois, The Johns Hopkins University, University of Loma Linda, University of Massachusetts, University of Michigan, University of Minnesota, University of North Carolina, University of Oklahoma, University of Pittsburgh, University of Puerto Rico, University of South Carolina, University of Texas at Houston, Tulane University, University of Washington and Yale University. Boston University and San Diego State University will be seeking accreditation in the Fall of 1980 and 1981, respectively.

**When federal support for Schools of Public Health began in the late 1950s, 11 Schools were training 2,000 students. Federal support has remained constant since the early 1970s.

Some of the fields of concentration offered by the Schools are:

- Behavioral and Social Sciences
- Biostatistics
- Environmental Health Sciences
- Epidemiology
- Health Services Administration, Policy & Management
- Health Education
- International Health
- Maternal & Child Health
- Nutrition
- Occupational Health & Safety
- Population Studies
- Public Health Practice & Program Management (e.g., public health nursing)

Graduates of the Schools of Public Health work primarily in the public sector in the areas of health promotion and disease prevention. They represent the basic resource pool from which Federal, state and local health and environmental agencies draw their manpower needs. Graduates also work and teach in university settings. Industry relies heavily on the Schools to train their employees involved in industrial hygiene, occupational safety and health, environmental toxicology, among others. The breakdown is as follows: 50 percent of graduates in a single given year go into federal, state or local government service, 34 percent work for either non-profit community health agencies or universities and 4 percent work for industry.

ASPH data shows that the Schools no longer primarily train professionals for state and local government agencies. In response to a demand for new types of health workers and a broader concept of public health, the Schools have made major efforts to train stduents in health administration and environmental health, now the two most frequently chosen areas of specialization. Health administration attracted 1,069 students in 1977-78, or 16.6 percent of the total. With health planning and policy studies counted in, that total would be even higher. Hospital administration, treated as a separate discipline, drew an additional 299 students (4.6 percent) in 1977-78. With biomedical laboratory sciences reported separately, environmental health narrowly displaced epidemiology as the second most frequently chosen specialty. Biostatistics ranked third with 440 students in 1977-78 (6.8 percent), while health education was fourth with 421 students (6.5 percent) and nutrition fifth with 382 students (5.9 percent).

Students who attend the Schools are often mid-career professionals with a prior commitment to public service. The average age is slightly over 30. A large percentage are part-time students already working in the public sector while upgrading their skills. It should be noted that a public health degree does not increase the income potential of the graduate as much as other health professions degrees. Schools of Public Health are in the business of training men and women for public service.

The 21 accredited Schools are two-thirds state owned and one-third privately owned. In FY 1974, less than one percent (0.9) of total state expenditures for support of health manpower training institutions went to public health.* The lion's share (64.5 percent) went to the training of phsyicians. None of the private institutions, except the University of Pittsburgh, receives state support. Private Schools by and large depend on the traditional means of private sector support such as endowments, tuition, gifts, etc., yet they are in the business of training workers for the public sector.

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*The Congressional Research Service is presently conducting a study to determine 1979 levels of state support to Schools of Public Health.

FEDERAL ASSISTANCE TO SCHOOLS OF PUBLIC HEALTH

I. Institutional Support

Federal assistance to encourage development of experienced public health professionals began with traineeship support in 1956, thus making federal aid to Schools of Public Health one of the oldest health manpower training programs. Federal institutional support was authorized in 1958 and the special project grants program began in 1960. Since the Federal assistance program began, the number of accredited Schools has almost doubled from 11 to 21 and the enrollment has increased fivefold, yet Federal support has remained constant since 1975.

The basic intention of Federal institutional support to public health schools is to increase the supply of health manpower in fields where the demand is high and/or where a shortage exists. The July 1979 Surgeon General's Report said that although there is a lack of public health manpower data,* there are definite shortages of certain specialized disciplines such as epidemiologists, biostatisticians, occupational and environmental health workers and health service administrators. The overwhelming majority of these professionals are trained in Schools of Public Health.

Institutional support to both public and private non-profit Schools has provided a general subsidy which may be used for any educational program of the Schools including teaching and community service. Such grants supplement other sources of income and permit a degree of flexibility in program development. For the newer and smaller Schools the institutional subsidy has stimulated growth and provides a measure of financial stability.

Providing basic institutional support is a means whereby the Federal government can share the costs** with states and private institutions for the training of public health personnel to manage and operate governmental health programs.

The Schools still need flexible but accountable funds which they can use to support parts of their overall program which have been weakened by insufficient Federal, state and local and private financing.

Adequate training and research funds are available in certain fields such as toxicology, nutrition, occupational safety and health to partially support students and to purchase supplies and equipment. However, there are no categorical funds available, except the old formula grants and the present capitation grants, that provide adequate support for curriculum development and program support.

ASPH believes that HR 6802 would provide the basic generic support for improving the quality of the curriculum and teaching techniques and enhance the capacity of the Schools to provide health promotion and disease prevention activities in the community.

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*Reasons for the lack of data are several, such as lack of uniform and fixed definitions and requirements for employment, methodological problems and high costs of gathering information.

**Teaching costs per student per year approximate those of medical schools. ASPH estimates that it costs $10,000 to train one public health student each year.

An alternative to capitation is needed because of the general disfavor of the program. While it has been effective in increasing enrollment, it has not been effective as a means of addressing the problems of specialty and geographic maldistribution. Dealing with these problems requires targeted programs of assistance. Basic institutional support would assure the health care system an adequate supply of public health professionals in defined national priority areas. HR 6802 targets financial support to categorical programs that are responsive to national health requirements and programs. The quid pro quo implied in Federal support is based on results in terms of increased minority enrollments, public service commitment of students and graduates attracted to specialty and geographic areas in need. Federal support, in terms of instituitonal, student, and curriculum assistance, challenges Schools to place emphasis on Federally defined priority areas. It ensures the training of professionals (such as health administrators, biostatisticians, epidemiologists, public health nurses, preventive medicine specialists, environmental and occupational health specialists, nutritionists, maternal and child health workers, among others) who would provide services in disease control, protection against health hazards, health services management, cost containment, health promotion as well as disease prevention.

The Administration has proposed the termination of capitation funds for all health professions schools in FY 1981 based on the assumption that capitation grants are incentive payments to Schools to increase their enrollment and are no longer needed since there is or will be an adequate supply of licensed health professionals in the 1980s and 1990s. Yet ASPH studies and two prepared by HEW* point out that the demand for the types of health manpower trained by Schools of Public Health will increase as a result of current and future legislative and Administration initiatives in the fields of disease prevention and health promotion (not to mention cost containment and improved management of health services delivery). These initiatives are looked upon as means to improve the quality of life and to reduce skyrocketing health care costs.

In view of the growing demand for health manpower stimulated by recent passage of Federal programs such as health planning, clean air, clean water, toxic substances, health maintenance organizations, older Americans act, nutrition programs, PSROs, and other federal initiatives such as cost containment, child immunizations, mental health, child health, health promotion, rural and urban health initiatives, among others, the ASPH believes that continued institutional support is justified by the nature of public health as a governmental enterprise aimed at the improvement of the public's health. Furthermore, the Schools of Public Health presently represent the major source of supply of trained personnel to implement and manage the Federal health programs and initiatives. Institutional support is simply a partial reimbursement of costs incurred by the Schools in providing comprehensive training of personnel for Federal, state and local governments, industry and voluntary health agencies charged with the responsibility of carrying out Federal programs and meeting Federal health requirements.

In terms of actual percentage that institutional support would represent as part of the federal health budget, the figure ($7 million) is miniscule. When one examines the percentage these grants will represent in the total operating funds of

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*A December 1979 report to Congress on Community and Public Health Personnel and the Surgeon General's Report, Healthy People. Also the Institute of Medicine and NIH have repeatedly stated that a short supply of epidemiologists and biostaticians exist.

Schools of Public Health, however, the percentage will be around 10 percent.

The Federal funds received by Schools of Public Health have been considered to be the Federal government's share of preparing public health personnel to meet the needs of public today and for the future. The amounts, while small in comparison to overall expenditures, have and will continue to contribute to the preparation of this vital health resource.

The capacity of the Schools to respond to emerging needs, to offer a balanced curriculum and to provide graduate training in critical areas which are unsupported by other funding sources would be severely reduced by the absence of institutional support. To delete institutional support now or in the near future will diminish the ability of the Schools to serve the Nation's health in the manner intended by those national leaders who first conceived the notion of financial support to Schools of Public Health.

ASPH supports Section 791 of H.R. 6802 because it provides stable support to the Schools of Public Health. This financial assistance would enable these public health graduate institutions to provide categorical educational programs and community services that are complementary to national public health shortage areas outlined in Healthy People. The quid pro quo implied in Federal assistance would be based on results:

- Increased supply of professionals working in nationally defined specialty shortage areas such as health administration and management, biostatistics, epidemiology, nutrition, gerontology, environmental and occupational health (including toxicology), health promotion, maintenance and disease prevention, among others.
- Increased supply of manpower needed to implement national public health and health care service programs.

The justification for continuing institutional support to students and Schools of Public Health is generally the same as it was 20 years ago when the program first began. Public health schools train personnel for public service. The Federal government has a direct interest in assuring that an adequate supply of public health personnel is trained in quality institutions to manage and operate the health delivery system in the national interest.

ASPH strongly urges the Committee to enact Section 791 of H.R. 6802. However, the bill should be amended to take into account the fact that requirements to increase student enrollment should be accompanied by adequate support to refurbish, renovate and construct additional facilities to accommodate the increases called for in Section 791(e)(2). Most Schools do not have the resources to adequately serve an increasing student population.

II. Student Assistance (Traineeships)

ASPH strongly urges enactment of Section 791 of H.R. 6802. It provides needed support to students entering or continuing their professional careers in public health.

When the "Health Professions Educational Assistance Act of 1976" was originally passed, Section 748 authorized traineeships for Schools of Public Health alone. Subsequently, it was discovered that preventive medicine and dentistry residencies had been overlooked in drafting the Act. This section was then amended to cover them and to include other public or non-profit institutions providing graduate training in public health. The authorization level was raised $1 million for each of the years of authorization to accommodate the expanded eligibility. However, these funds have never been appropriated.

ASPH requests the Committee to seriously consider striking out Section 748(b)(4) of the expiring act (P.L. 94-484). This present traineeship authority requires that a specified percentage of these awards shall go to students with a post-baccalaureate degree or with three years work experience in health services and who are pursuing a course of study in designated areas of specialization. To implement this provision, Schools must stress recruitment of older students with prior work experience or other professional degrees that discourage recruitment of recent college graduates. This provision was based on the mistaken notion that Schools of Public Health should only train senior level administrators and policy makers (i.e., the leadership cadre) rather than operational level personnel. This provision should be deleted from H.R. 6802.

The traineeship program is intended to attract high caliber students and to offer the economically disadvantaged, especially minorities, an entry point into the system. The rising cost of tuition and other expenses will make it even more difficult for low-income students, perticuarly minorities, to afford graduate education in public health schools. Furthermore, many undertake graduate study in public health at mid-career and have important family obligations. Others have already accrued heavy debts from their previous education. Over 77 percent of students received some form of financial help in 1978-79.

The graduates, unlike many of the other health professions, do not enjoy lucrative incomes. Over 90 percent of the graduates are employed by governmental and community agencies and universities. Their modest salary levels are reflected in a recent survey which showed an average of only $30,000 after 15 years of experience. Of the 1979 graduates, 57 percent earn less than $19,000 per year, 17 percent $19,000 to $22,000, and 20 percent $25,000.

Calculated in constant dollars, traineeship support has declined by 48.6 percent since 1970 with enrollments growing in that same period (52 percent). This has meant less money to be spread among more students.

It should be noted that the limitation on the amount of an individual traineeship award puts the Schools of Public Health at a competitive disadvantage in recruiting physician students in residency programs. In revising P.L. 94-484, ASPH urges Congress to provide the same latitude on the amount of traineeship funds allocated to physicians in clinical residency programs in medical schools. This concern is adequately addressed in Section 794(D).

Traineeship support to students in Schools of Public Health is justified on the grounds that a majority of our students enter (or re-enter) public service. A recent ASPH survey* of 1979 graduates shows that 50 percent worked in tax supported agencies of the Federal, state, regional and local governments and 26 percent worked for voluntary and non-profit, private health organizations. Over 32 percent of the 1979 graduates are providing public service administrative, planning or evaluation services, 15 percent education or other training services in public health, 5 percent public health community organizational services and 38 percent are providing technical services such as clinical, laboratory, social and environmental services.

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*Survey and analysis by Thomas Hall, M.D., of the School of Public Health at the University of North Carolina.

Again, Schools of Public Health train men and women* primarily for service in the public sector in the areas of health promotion, disease prevention and in the organization and administration of health services.

III. Special Projects

ASPH supports the special projects grant section of H.R. 6802 (Section 793). This section goes further in greatly re-gaining the losses to the Schools brought on by inflation. As inflation has gone up, Federal assistance in special project grants has gone down. In FY 1973, the Congress appropriated $6 million for special projects; in FY 1980 it approved $5 million which represents $3.3 million in 1972 dollars. Yet School enrollment increased 40 percent since 1973.

These grants are used for projects that are designed to place emphasis on curriculum in the areas of national public health manpower needs (epidemiology, biostatistics, health administration, nutrition, gerontology, environmental and occupational health, maternal and child health, among others). These grants are used to complement Federal initiatives that are stimulating a growing demand for public health personnel.

The special project grants program began in 1960 and was intended to aid accredited Schools of Public Health to develop new programs and expand existing programs in biostatistics and epidemiology, health administration, health planning, health policy analysis and planning, environmental and occupational health and dietetics and nutrition. An amendment by the 95th Congress opened this authority to any educational entity offering programs in the above areas without increasing the authorization level.

Project grants provide support for the development of training opportunities in public health to meet emerging national priorities for public health manpower competencies. These include the training of leadership for management and specialized responsibilities in new and projected health agencies such as HMOs, PSROs, HSAs and agencies to control environmental health hazards.

Project grant appropriations have been decreasing since 1973. Inflationary pressures have accelerated that decline. Calculated in constant dollars in the FY 1980 appropriation of $5 million is 40 percent less than the amount appropriated in FY 1973.

Further, Schools of Public Health do not receive all of the money appropriated. As a competitive program, Schools of Public Health must now compete with all programs in health administration, environmental health, nutrition and other educational entities offering training in the specified fields. However, we support Federal assistance to these programs since they greatly contribute to the needed public health manpower pool.

ASPH joins the Association of University Programs in Health Administration in supporting the increased authorization levels in H.R. 6802 for special project grants to Schools of Public Health and graduate programs in health administration. Here is the justification. Training and research funds are available in certain fields such as toxicology, nutrition, occupational safety and health to partially support students and to purchase supplies and equipment.

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*In 1977-78, 49 percent of public health students were women.

However, there are no categorical funds available, except the old formula grants and the present capitation grants, that provide support for curriculum development and program support. ASPH believes that increases for special project grants would provide the basic generic support for improving the quality of the curriculum and teaching techniques and enhance the capacity of the Schools and health administration programs to provide health promotion and disease prevention as well as health services management activities in the community, state and Nation.

IV. Preventive Medicine,Dentistry and Public Health Residencies

ASPH supports Section 749(D) that provides support for residencies in public health and preventive medicine. Healthy People underlined the need to increase the supply of professionals in these special practice areas. Also a recent Institute of Medicine report, "A Manpower Policy for Primary Health Care", made a number of recommendations including one to increase the number of residency positions in preventive medicine.

ASPH concurs with its sister organizations, the American College of Preventive Medicine and the American Teachers of Preventive Medicine, in their efforts to have Congress recognize the special needs of programs in preventive medicine. They maintain that if a change is to be effected in the health care system to bring about a greater emphasis on prevention, a change must be made in the attitudes and behavior of the medical profession. Medical students, and hence physicians, are not trained to understand the potential of prevention. To promote an awareness of prevention within the medical profession, it is necessary to foster integration of prevention principles within federal policy regarding health manpower training. These organizations (including ASPH) are pleased that H.R. 6802 attempts to accomplish this by providing incentives for medical schools to integrate prevention within their curriculum and by providing direct support for departments of preventive medicine and residency training to students in preventive medicine in Schools of Public Health. However, ASPH urges the Committee to allow those Schools of Public Health that serve as departments of preventive medicine or dentistry for on-campus medical schools the opportunity to participate in programs outlined in Section 794(C).

V. Continuing Education and Health Policy and Management Training

ASPH urges the Committee to enact Section 794 of H.R. 6802 that targets funds for continuing education programs designed to train on-the-job professionals in the latest developments of health policy, management, finance and administration. Recent enactment of Federal health and environmental laws, plus expanding expectations for health, increased public participation in personal and national health affairs, greater demand for cost containment and improved health services management, and the national debate for passage of national health programs, all have created a demand for the upgrading of skills for professionals working in health promotion and disease prevention and health administration fields. According to recent reports, of the approximately 150,000 people from the public health work force, only 25 percent are graduates of Schools of Public Health or other health professional training programs. One-half of the total requires short-term re-training in order to help them keep up with the growing complexities of health programs and the ever increasing base of knowledge and technology. Section 794 should also provide funds to Schools of Public Health to conduct programs in traditional areas of continuing education.

There is an urgent need for trained policy planners and managers throughout the health system, including many in public and private non-profit agencies and institutions that are not directly engaged in the provision of hands-on care for the ill, but do impact on the availability, quality and cost of medical care, and on health services generally, including disease prevention, health promotion, and protection of the public from hazards to health (radiation, toxic substances, air and water pollution, etc.).

ASPH urges the Members to support programs that effect constructive change by widening the perspectives and increasing the management capabilities of senior and mid-level executives and leaders who are responsible for directing health agencies such as HMOs, HSAs, community health centers, hospitals, state and local health departments, environmental agencies, among others.

ASPH also urges the enactment of Section 216. This section authorizes support for Area Health Education Centers.

VI. Facilities Maintenance

ASPH urges the Committee to approve provisions in the health manpower act that provide assistance to Schools of Public Health for construction, renovation and/or refurbishment of facilities to provide appropriate teaching and research environments for students and faculty. H.R. 6802 would support the Schools in expanding their programs in vital public health disciplines to incorporate the necessary elements which ASPH maintains are so desperately needed. However, the bill does not provide funds for additional space requirements that would be needed if H.R. 6802 is enacted.

Present plans to terminate grants for construction and extremely limited funds for renovation of teaching facilities, ignore the implications of federal laws, initiatives and the Surgeon General's report which will stimulate the growing demand for public health manpower. If assumptions regarding growing demands are true, the Schools of Public Health will need the construction grants in order to expand their facilities to accommodate the necessary increase in enrollments. Many of the 21 Schools of Public Health are operating at their capacity level. Expansion of enrollment to meet the growing demand will mean overcrowded and inappropriate teaching conditions.

VII. Health Personnel Data and Manpower Projections

ASPH requests extension of Section 793 of P.L. 94-484 that asks the Secretary to collect, compile and analyze data on all sectors involved in the health services delivery system. With the demands being placed on the Schools of Public Health to provide data to the executive and legislative branches of the Federal government, it becomes imperative that a centralized system of data collection be continued. At the present time such a system is operating and can provide information on applicants, students, graduates, faculty research projects and expenditures in Schools of Public Health. Because of the need for authentic data produced in a timely fashion, Federal funding is necessary to maintain surveillance on public health manpower production in the Schools of Public Health. Also, this type of data collection and surveillance needs to be extended to other schools and programs that produce specialized health manpower personnel.

Further in an effort to monitor the ability of the production system to fill manpower requirements of the work force, studies must be undertaken to assess public health manpower requirements in all sectors of the health delivery system, especially in the public sector. Contrary to the other health professions (physicians, nurses, dentists, pharmacists, veterinarians, optometrists, etc.) no federal studies have been undertaken on the need for the present or future supply of public health workers.

ASPH urges the Committee to provide assistance to not only conduct studies to determine the demand for public health personnel, but to determine the cost of educating and training community and public health workers, as well as identifying functional and geographic areas in which there are shortages in national priority needs.

VIII. The Administration's Proposal

The Administration's bill proposes to end capitation but it does continue to provide limited support and curriculum development monies to Schools of Public Health and programs in health administration.

ASPH is puzzled as to why the Administration proposes to incorporate specific public health authorities (Sections 748, 749, 791, and 792) into the more general authority for special projects (Section 788), and yet stipulate in its proposal and in FY 1981 budget justification documents that funds appropriated under Section 788(d) be earmarked for public health and health administration along with projects for the MODs and VOPPs. If public health is a high priority area in the Administration's game plan (Healthy People), then the specific authorizations for public health traineeships and special projects should be left intact in the bill. The bill proposes that $17 million be shared with all of the schools of the health professions. This figure is currently shared by the Schools of Public Health and graduate programs in health administration alone.

Recent HEW reports to Congress state that a short supply of public health personnel exists in our Nation. It is surprising and confusing, therefore, for the Administration to propose drastic reductions in Federal support to Schools of Public Health. Given the present state of the economy, certain reductions in Federal spending is justified. However, to recommend cuts in programs that contribute to keeping individuals out of the medical care system does not make sense. Cost savings in the health care system can be achieved through greater emphasis (not reductions) on programs that keep people and communities healthy.

IX. Summary

ASPH urges the Committee to include references to public health in the preamble of the bill that would amend P.L. 94-484. ASPH suggests that the revised act be complementary to the Surgeon General's report Healthy People:

> It is the thesis of this report that further improvements in the health of the American people can and will be achieved -- not alone through increased medical care and greater health expenditures -- but through a renewed national commitment to efforts designed to prevent disease and to promote health.

Further, the preamble should note another finding in Healthy People:

> In the field of public health, in contrast to personal health, manpower shortages are believed to exist in some key fields, including occupational health, epidemiology, biostatistics, and health services administration.

In summary, the ASPH believes that continued Federal assistance is actually an investment at the front end of the health care system. The Schools (i.e., through their students, graduates, researchers, faculty and community service programs) will not only help prevent illness but will also help slow down the rapidly escalating costs of medical care. Providing basic institutional and student support is a means whereby the Federal government can share the costs with state and private institutions for the training of public health personnel to manage and operate governmental health programs. Public health is a public responsibility. Schools of Public Health train personnel for public service. The Federal government has a direct interest in assuring that an adequate supply of public health personnel is trained in quality institutions to manage and operate the health delivery system in the national interest.

ASPH thanks the Members of the House Interstate and Foreign Commerce Subcommittee on Health and the Environment for the opportunity to present its views on H.R. 6802, the "Health Professions and Educational Assistance and Nurse Training Amendments of 1980". ASPH urges favorable consideration of H.R. 6802 with suggestions outlined in this statement.

Mr. WAXMAN. Thank you very much. Certainly those statements will be made a part of the record.

Dr. Filerman.

STATEMENT OF GARY L. FILERMAN, PH. D.

Dr. FILERMAN. Thank you.

Mr. Chairman, the activities of this committee to develop an effective health manpower policy are particularly important to the schools which I represent. I am Gary Filerman, president of AUPHA, a consortium of those universities and colleges in the United States that train the administrators, managers and planners of health services.

This committee was instrumental in giving recognition in public policy to the problem of management of health services, which resulted in an effort to improve health administration programs in universities through Public Law 94-484. The purpose of that support is simply to make the system work.

Let me demonstrate the core of the problem. The fact is that many of the health professionals whose training you have been discussing in these hearings will not be optimally productive because of inadequate management in the settings in which they practice.

Geographic distribution improvement is hindered by poorly managed rural and city center health facilities and programs. Cost containment is a myth if management cannot read a balance sheet or install systems to control the use of expensive resources, systems which, in fact, in many cases are in place in industry today.

No amount of tinkering with the health planning legislation is going to make an incompetent planning staff effective or respected by providers in the community. We know that many HMO's are virtually on the edge of collapse because of inadequate management. Propping them up with Federal transfusions costs millions of dollars which could be saved by better management, while every failure destroys public confidence in the future of HMO's.

We know from many Federal executives that the problem of under-management thwarts the efforts of the Congress in virtually every Federal health initiative. Complex organizations, entrusted with lives, billions of public dollars and careers paid for by the public must be managed well, but the fact is that many are not.

The most serious problems are in home health agencies, community health centers, HMO's, rural and urban public general hospitals, and nursing homes. Not only do such organizations not invest adequately in management, but adequately trained management is frequently not available.

The professionalization of health administration is a fundamental strategy to stimulate efficiency and efficacy in the system. That is what health administration programs are doing. The bill which you consider should provide the basis of that strategy.

The support started 2 years ago with the help of this committee has led health administration programs to be much more effective in attracting bright, motivated young people to careers in the management of the health services. It has increased the number of programs which provide training, and it is increasing the number of graduates. It is improving the quality of training; providing administrative training to students in other health professions—which is a critical area of need—improving the management skills of people on the job; providing technical assistance to planning, regulatory and delivery organizations at the community level.

The bills the committee is considering recognize the need to improve health management training capacity. What is needed, in summary, is this: Capacity building support for the health administration programs which encourages expanded non-Federal support; student assistance which improves the competition, particularly with general management and for minority group students.

Student aid programs should recognize that 95 percent of health administrators are employed in the public and nonprofit sectors. The bill should support approaches to exposing students and graduates to the many managerially underserved health services, most of which cannot pay to train their managers.

It should include an attack on the acute shortage of faculty members who are competent to respond to rapidly expanding needs for teaching, technical assistance and systems improvement research. And finally, it is time for a systematic appraisal of management needs developed in other sectors of our society, particularly industry, which hold promise of improving the efficiency of health services.

It is vital to the work of this committee to recognize that the significant health care developments of the 1980's will be organizational.

Mr. Chairman, the universities look forward to working with the committee in this effort which is so fundamental to the success of so many other health initiatives. We would appreciate having our detailed comments on the bills included in the record.

Thank you.

[Testimony resumes on p. 471.]

[Dr. Filerman's prepared statement and attachments follow:]

STATEMENT OF GARY L. FILERMAN, PH. D., PRESIDENT ASSOCIATION OF UNIVERSITY PROGRAMS IN HEALTH ADMINISTRATION

Mr. Chairman and Members of the Committee,

I am Gary L. Filerman, President of AUPHA, a consortium of 116 colleges and universities involved in health services administration education. The mission of this public service corporation demonstrates the growing demand for the nation's educational resources to respond to the vast management training requirements of health services. AUPHA brings together graduate and undergraduate schools and programs based in schools of medicine, public health, business administration, public administration and allied health in one coalition effort to focus scarce resources on a critical issue which permeates the health system at all levels, in all communities and all institutions. That problem is the shortage of personnel who are competent to manage the most complex, expensive and necessary of community services.

The Problem

Health services administrators live with the results of the work of this Committee. They deal every day with problems of specialist availability, nursing shortages, roles of new professions, personnel costs and practitioner competence. Every aspect of health manpower policy affects their work, and they have a significant influence upon the success or failure of that policy. Good management can make better use of scarce resources. An effective administrator creates the conditions under which health professionals are optimally productive by assembling resources, arranging appropriate staffing and making sure that quality control systems function properly. Effective administrators assess community needs, guide institutions and programs to respond and help communities understand the needs and roles of health services. They make sure that the community's investment in people, facilities and equipment is protected. They bring professional skills, standards and commitment to planning, rate setting, quality assurance and the development of new services. Such professional management skills are essential to the delivery of quality health services on an equitable and cost-effective basis.

The fact is, however, that management competence in health services is grossly uneven and the problem is growing. There are few management responsibilities which offer a greater opportunity to directly affect the quality of community life. But the demands of the position are extraordinary. Public accountability means management must respond to the information requirements and management regulations of many public agencies, which limit managerial options. The problem of securing support by appropriation, reimbursement, charges, borrowing, or contributions is dwarfed by the challenge of working with labor unions, medical societies, accrediting organizations and community interest groups.

The problem of undermanagement in health organizations has been overlooked for years because of two reasons. First was the assumption, now disproved, that producing more practitioners of all kinds would solve problems of service availability. The second reason is that the most conspicuous health service is the community general hospital, which commands the best management resources in the system. Many federal initiatives to meet health service needs, either directly or indirectly, have limited success because they outrun the management available to them. Pumping more money into the health system without better management technology is like putting billions into the space program without first developing the basic technology needed.

There are not enough appropriately-trained administrators. In addition, some regulations limit the investment which can be made in management. There are serious management shortages in HMO's, emergency medical systems, nursing homes, home health agencies, community health centers and rural and urban public general hospitals. The Labor Department has identified administration as the health career with the largest unmet need in the next decade. The result is that:

* Many of the health professionals whose training you have been discussing in these hearings will not be fully productive because of inadequate management of the settings in which they practice.
* Geographic distribution will continue to be hindered by poorly managed rural and center city facilities and programs.
* Cost containment efforts will have limited effectiveness because of the inability of managers to install systems to control the use of expensive resources, to deal with the information which they produce, and to interpret it effectively to providers and to the community.

- * No amount of tinkering with health planning legislation will make an incompetent planning staff effective or respected by providers and the community.
- * Many existing HMO's are on the verge of failure because of inadequate management. Propping them up with federal transfusions costs millions of dollars which could be saved by better management, while every failure reduces public confidence in the future of HMO's.

This is cost-containment legislation of the most fundamental and far-reaching kind.

Legislative History

PL 94-484 provided the first support to specifically improve and expand health services administration programs in universities. Previous health manpower legislation provided support to schools of public health, but it was not earmarked for their administration components. Programs in other settings, that is the most programs with the most graduates, were eligible only for competitive project grant funds which were spread over many fields, with the result that relatively few programs received improvement assistance.

PL 94-484 provided grants to build the service capacity of accredited graduate programs outside of the schools of public health. The grants were well targeted to improve the program's effectiveness by requiring a floor of nonfederal support, a minimum class size, increased enrollment and accreditation. The programs were also provided with a modest amount of traineeship support intended to increase their ability to serve people with experience in health work, attract minority group members and compete for unusually strong talent.

Under 94-484, the programs based in schools of public health continued to be included in the general support of the schools. Traineeships were allocated through the school. Project grant support was available from the same general pool of competitive funds to which literally hundreds of public health related programs have access.

About a third of the programs in health administration are based in schools of public health. Therefore, general support to schools of public health is very important to the improvement of management training capacity.

Because of forward funding, the graduate programs in health services are now completing only the second year of federal support. There has already been substantial progress toward accomplishing the objectives of the federal support.

The principal objective of PL 94-484 was the establishment of a national network of university based health administration training centers which are capable of:

- Attracting and providing quality education for an expanded number of professional health administrators;
- Providing continuing education to improve the knowledge and skills of administrators and planners throughout the system;

- Contributing administrative and health systems content to the education of other health professionals;
- Providing technical assistance to delivery, regulatory, financing and planning agencies in their service areas; and
- Conducting needed health services research.

The Record

As a direct result of the health services administration sections of PL 94-484;

- The number of students graduating from accredited graduate programs outside of schools of public health has increased from 720 in June, 1977, to 822 in June, 1979, a 14.2% increase.
- The number of accredited graduate programs has increased from 21 in 1977 (June) to 25 in 1979.
- The level of nonfederal support for several programs has been increased significantly.
- Continuing education and technical assistance activities have increased substantially, especially focusing upon cost containment, strategic planning, financial management and labor relations.
- Graduate faculties have increased in numbers, thereby expanding capacity for service.

The effort to improve training capacity for management under PL 94-484 is beginning to pay off. It is already a cost-effective public investment and will be more so if continued.

The federal government must stimulate greater efficiency in the health system. The professionalization of health services management, including planning and regulation, is a fundamental strategy for improved efficiency. There has been substantial progress in improving professional education, a foundation of professionalism.

What is Needed

Programs in health services administration are essential resources in the effort to improve the efficacy of health services. Every dollar invested will pay short and long term dividends if the programs develop and sustain the necessary critical mass of skills. Present programs are small--they frequently have only five or six staff members. Before PL 94-484, these programs had a staff of only three or four professionals.

The larger size makes it possible to add specialists in such critical fields as finance, long-term care, HMO management and continuing education. Therefore, there is a direct relationship between the number of students enrolled and the size of the faculty; between scope of services offered to the community and program "critical mass".

The support under PL 94-484 had direct and effective impact on that balance. Therefore we recommend that support to develop the basic capacity of health administration programs be continued for three years.

The targeting of this support can be focused to guide the programs toward optimal response to public policy priorities. The required nonfederal first-dollar support is a good example. Several of the programs are now on a firmer support base as a result.

The enrollment increase requirement has been a definite factor contributing to a 14% increase in graduates from eligible programs over the past three years.

Accreditation assures minimum core of content and orderly assembly of resources across all settings where programs are based. Programs based in medicine, public health, business administration, public administration and other settings have a common frame of reference. That framework is the product of a fully recognized accrediting agency composed of: The American Hospital Association, The American Public Health Association, The American College of Hospital Administrators, The American College of Medical Group Administrators, The American College of Nursing Home Administrators, The American Health Planning Association, The Association of Mental Health Administrators and The Association of University Programs in Health Administration. The purposes of providing support to students to train in health management are:

1) It is essential that health administration successfully compete for the most well-prepared and motivated young people. The field does not now receive its share of talent which the public responsibility for health services management requires.

2) The programs need to sustain their ability to attract experienced health workers. The average age of 1979 graduates was 29.3, indicating the appeal of graduate education in this field for mature students. This average also indicates that many have family obligations which would keep them from school if traineeships were not available.

3) The most consequential role for a minority group member in health is the management and planning of community health services. The 13% minority graduation rate in 1979 demonstrates the ability of the programs to attract minority students and demonstrates the need for effective, flexible student aid. Therefore we recommend:

A system of traineeship support designed to improve the recruitment of potentially excellent administrators, and which gives the programs the flexibility to assist each student in the most effective way, commensurate with national priorities.

The most stable characteristic of health service management is change. The programs must develop individuals who are prepared to manage organization change. A "change agent" in the best sense commands skills which are basic to management of large complex organizations, understands the forces which dictate change and has professional objectives of public service which give direction to his efforts. The programs must assess the change process in the real world, project developments and revise curricula, ideally to be ahead--to be training for tomorrow as well as today.

Grants for special projects facilitate adapting to changing needs. Programs need to develop new curriculum materials for the management of cost containment, control of growth and resource scarcity. Multi-unit systems and shared services require new management skills, which are being identified by studying such organizations in health and in industry. Revising curriculum, organizing specialty tracks and developing new continuing education offerings are major projects which must be supported if health administration training is to keep up with the demands of the system.

Project grants are an effective change strategy because they can be targeted to national priority needs. They also require well-developed, competitive applications for which a program must organize resources and provide basic data necessary for an effective implementation plan and evaluation process. They are necessarily "stop-and-go" stimuli and very different from capacity development grants which are designed to encourage organizational stability. To use public funds well, projects should have specific end points at which developmental work is integrated into the ongoing program, freeing project funds for further "cutting edge" activities. Therefore, what is needed is:

Provision for grants which facilitate change, adaptation and innovation in health administration education, and which encourage response to national priorities and quality through peer review.

Capacity development, student support and special project grants are the most cost-effective and potent means to realize the potential of an improved health services administration system. However, the amount of dollars which the existing and new programs can put to effective use is limited because of the acute shortage of appropriately-trained faculty members.

Carefully planned faculty development effort will meet the needs of the programs as their capacity expands. Only two or three years before the effort to improve management training capacity began, the production of faculty practically dried up. Additional well-trained faculty are needed to carry forward our health services instruction, research and system improvement agendas.

The principal sources of doctoral level talent were programs sponsored by the National Center for Health Services Research and the W.K. Kellogg Foundation. Those programs have ended. There is now very little doctoral training specifically geared to health services administration. Individuals with a doctoral degree in a discipline basic to health services, such as economics, political science, sociology, operations research, finance or organizational behavior need substantial orientation to the health applications of their fields before they can effectively contribute. The same applies to such key specialists as lawyers and C.P.A.'s. On the other hand, physicians, dentists and other health specialists lack disciplines which provide broader perspectives and analytic skills. There is no system in place for meeting the current and expanding need for doctoral level health administration program and faculty leadership. Programmatic or fellowship support for faculty development is an essential element of improving the management training system.

Legislative Options

PL 94-484 provided a cost-effective foundation for improving our management capacity. It did so first by assuring the essential viability of schools of public health, the breadth and depth of which is the spawning place of many essential components of this profession. It also nutured more targeted health administration efforts in other settings, thus engaging the resources of many more universities and serving many more communities. It is a unified strategy which directly supports federal efforts in prevention, planning and management.

H.R. 6802 continues that strategy with some improvement in health administration program support and a strong continuing education authority.

We believe that the all-out effort to reduce the rate of increase in health costs mandates a new strategy which builds upon the foundation of PL 94-484. This new strategy should recognize that health administration programs are capable of doing a lot more than training entry level personnel. It should also employ the potential of many practitioner organizations and the proven skills of American enterprise to increase the productivity of scarce and expensive health resources.

H.R. 6802 continues project grants for schools of public health, programs in health administration and other public health related programs. This authority carries an authorization level which is the same as the past three years. It is, in fact, a major decrease in support for the national priorities in public health and health administration. The original authority level was a realistic figure based on what the programs could and needed to do to introduce new programs and update existing ones. But, many other programs were made eligible for the same funds, which was not the intent of this committee when the Bill was written and the authorization levels set.

To restore the project grant effort to effectiveness, we recommend that this authority be restricted to the accredited schools of public health and the accredited programs in health administration. A distinct authority should be established for other public health related programs, many of which are not in fields which are well defined by accreditation and not so clearly central to national priorities at this moment.

The traineeship authority for health administration is Section 794B. This section currently includes language which has reduced optimal use of the support by imposing a requirement that a high proportion of the funds be allocated to certain students. The allocation was based on a system of defining the role of the programs and of the public health schools which was never implemented. It is a regulation without any frame of reference and should be dropped. This provision has made it particularly difficult to target traineeship support to minority students. We also suggest that the phrase "program in health administration" be used uniformly in this section to include related activities in planning, policy and the several other specialty areas. This is the common usage, encourages integrated professional education and effective use of educational resources.

Section 794A provides for Capacity Improvement grants to accredited graduate programs. These grants encourage nonfederal support, the level of which can now be increased modestly. The purpose of the support is to develop capacity which is fundamental to the improvement of the health system. The "critical mass" of the programs is increased so that they can not only train more students but provide continuing education, technical assistance and health services research.

The authorization levels should be modified to $3,500,000 in 1981, $4,000,000 in 1982, and $4,500,000 in 1983. The current appropriation level of $3,000,000 has yielded progressively smaller grants in each of the past three years as the number of programs has increased. A number of already established programs will become eligible over the next three years (Appendix C), further reducing the grant. Unless the authorization level is maintained at a level which will assure the nonfederal contributions, the basic strategy won't work. The result will be a contraction of program services away from those activities with the highest immediate pay-off in system improvements.

H.R. 6802 provides a critically needed authority to provide advanced training for individuals in administration of health services. These grants should serve as seed money to launch needed programs which may become self-supporting. They would go to wide variety of organizations and institutions which have access to administrators who can benefit from such programs. The authority is timely and well-conceived.

Mr. Chairman, we urge the Committee to broaden the scope of the health administration provisions of H.R. 6802. We would then have a systemwide strategy to improve cost-containment, health planning and the managerially underserved elements of the system which are the low-cost alternatives. This strategy would include improved entry level education; expanded capacity for entry level and continuing education as well as technical assistance; developing management for managerially underserved health services; strengthening the management improvement impact of voluntary organizations and assessing needs and untapped technologies.

The "bottom line" is that the practice of management at the community level would benefit directly and there would be long-range, lasting improvements.

We suggest that instead of the traditional traineeships, there should be fellowships with a built-in "payback" provision. Support would be provided for the two year graduate program followed by a year of university supervised service in a managerially underserved health activity. This would give program graduates a chance to experience work in HMO's, community health centers, planning agencies, etc., which now receive few, if any, professional health services administrators. Such facilities usually lack funds to bring in young administrators.

We also urge the Committee to establish fellowships to develop faculty resources. There is a definite limit on the amount of support which the programs can use well. The reason is that there is a marked shortage of faculty who are qualified to respond to the growing education, service and research demands of health services. Part of the problem is the difficulty in using individuals whose training in any one discipline or profession is too narrow, as I outlined earlier.

There is a creative, cost-effective, moderately-priced solution to the problem. This solution can help solve the problem of underemployment of faculty in some of the disciplines which are being affected by decreasing enrollments in other fields. We urge the establishment of fellowships to "recycle" well-trained individuals to bring them into our field. This would include Ph.D.'s in such fields as economics, systems engineering, political science and management. It would also be aimed at C.P.A.'s, L.L.B.'s, M.D.'s, etc. Modest support ($1 million a year), would provide for three to six programs with three fellows each. The one-year long programs would introduce potential faculty to the job market in a short time and at a low cost. We recommend that accredited programs and schools of public health be eligible for such grants.

This integrated management development strategy requires a well-focused project grant authority which invests in accredited programs in all settings. We recommend a specific new authority for projects to develop and improve curriculum in health finance, health marketing, health economics, epidemiology, health planning, health policy, health law, quality assurance and information systems. Projects should also support efforts to teach health services organization and management to students in other disciplines. At least $3,000,000 should be authorized for this purpose.

Mr. Chairman, it is vital to recognize that the significant health care developments of the 80's will be organizational. Among the emerging patterns and issues are:

- The growth of chains on multiunit systems of both hospitals and nursing homes
- The increasing size of hospitals
- The development of day surgical centers
- HMO growth
- Increasing viability of Home Health Services

- Demands for access to high cost technology
- Assessments of PSRO and Planning Agency effectiveness
- National health insurance

There is only one possible conclusion: we are headed for larger, more complex organizations and constant change. But in health, large organizations have been more influenced by tradition than by change in the organizational sense. In contrast, industry has been more successful in accepting both large size and change as normal. We need to know a great deal more about the adaption systems and management technologies used in industry and their potential for health applications. We also need to know much more about the needs in the health field. Assessing both, systemmatically and together, will lay the groundwork for an effective public policy for organizational development. This is long-term, effective cost containment for a relatively low investment.

A very tightly focused study is needed to also assess unmet educational needs and to profile career development. It is important to understand the interaction between health and industry in respect to management, the pattern of which appears to be changing. Finally, the study should cut through the rhetoric on both sides to find out just what are the effects of various federal policies on the effectiveness of health management.

This study would build upon the work of the W.K. Kellogg Foundation Commission on Education for Health Administration. In 1973, this public commission found that "only about 25 percent of currently practicing health administrators have had formal education for health administration practice and that most of the 25 percent are practicing in hospitals and public health agencies". The Commission went on to urge greater public support for professional education. It did not look at industry, or at the impact of federal programs in administration effectiveness.

We believe that the Congress and HEW need to know much more about the management capacity issue. The data should come from an independent study.

Mr. Chairman, when every public dollar spent is being so scrutinized, we have no reservations about claiming additional support for health administration education. These dollars help assure the effective use of all investments in the health of Americans. No significant enterprise has survived lean times without investing in management competence. That is the first lesson from industry.

APPENDIX A

NUMBER OF ELLIGIBLE ACCREDITED PROGRAMS

As of 7-1-79	25 programs
As of 7-1-78	23 programs
As of 7-1-77	21 programs

NUMBER OF GRADUATING STUDENTS FROM ELLIGIBLE ACCREDITED PROGRAMS

1979	822 individuals
1978	749 individuals
1977	720 individuals

The number of graduating students increased by 4.03% between 1977 and 1978 and 9.75% between 1978 and 1979. The increase in graduating students between 1977 and 1979 was 14.17%.

APPENDIX B

ACCREDITED MASTER'S PROGRAMS IN HEALTH SERVICES ADMINISTRATION IN NON-SCHOOL OF PUBLIC HEALTH SETTINGS

GEOGRAPHIC LOCATIONS

ALABAMA

University of Alabama-Birmingham

ARIZONA

Arizona State University

COLORADO

University of Colorado

DISTRICT OF COLUMBIA

The George Washington University

GEORGIA

Georgia State University

ILLINOIS

University of Chicago
Governors State University
Northwestern University

IOWA

University of Iowa

MASSACHUSETTS

Boston University

MISSOURI

University of Missouri-Columbia
Saint Louis University
Washington University

NEW YORK

City University of New York
Cornell University

OHIO

The Ohio State University
Xavier University

PENNSYLVANIA

Pennsylvania State University
University of Pennsylvania
Temple University

TEXAS

Trinity University

VIRGINIA

Medical College of Virginia, Virginia Commonwealth University

WISCONSIN

University of Wisconsin-Madison

APPENDIX C:

MASTER'S DEGREE PROGRAMS IN HEALTH SERVICES ADMINISTRATION WHICH WILL APPLY FOR ACCREDITATION DURING 1980-1983

GEOGRAPHIC LOCATIONS

CALIFORNIA

California State University-Northridge
Golden Gate University
University of Southern California

DISTRICT OF COLUMBIA

Howard University

FLORIDA

Florida International University
University of Florida
University of Miami

INDIANA

Indiana University

KANSAS

University of Kansas

MISSISSIPPI

University of Mississippi

NEW YORK

Long Island University-C.W. Post College
New York University
Union College

OHIO

University of Cincinnati

TENNESSEE

Meharry Medical College

TEXAS

University of Dallas
University of Houston-Clear Lake City
Texas Women's University

Mr. **Waxman**. Thank you for your testimony. Your detailed comments will be made a part of the record.

Dr. Peterson.

STATEMENT BY KENT W. PETERSON, M.D.

Dr. **Peterson**. Thank you, Mr. Chairman.

My name is Kent Peterson. I represent the American College of Preventive Medicine, a small organization of approximately 2,000 physicians who specialize in preventive medicine, in particular areas, including public health, general and clinical preventive medicine, occupational health and aerospace.

I want to comment on particular sections of H.R. 6802, particularly those dealing with manpower training in preventive medicine, a subject of particular importance in a time of efforts to restrain rises in health care costs, at a time when inflation is rampant in so many sectors of our health care system and our economy.

Preventive medicine is that branch of medicine which deals with the well person, with efforts to keep the person well, to maintain health, to detect risk factors before disease, as well as to screen and treat disease itself. It is performed in an increasing number of clinical settings, and specialists in preventive medicine serve as teachers in medical schools of all physicians, as well as researchers doing research in risk factor detection in health promotion, as well as in serving the needs of public health departments, State health departments, occupational health, industry, et cetera.

Preventive medicine is an interdisciplinary or multidisciplined science. In addition to the skills required of all physicians, a number of core tools need to be added to the training of every physician: training in nutrition, which is extremely lacking in most medical school curricula; training in management, training in epidemiology and biostatistics; training in environmental health.

It is these particular skills which need emphasis and are given emphasis in these sections of the bill.

Let's review for a moment the relationship of preventive medicine to medical school curricula. My testimony outlines eight reports beginning in 1910. It is fascinating reading to look at the evolution of preventive medicine in this century in this country. The concern at the turn of the century was with the control of communicable diseases.

If you look at the statistics, virtually all of the top 10 killers and cripplers have been reversed because of efforts in preventive medicine. We are now witnessing a new era of concern about health promotion and disease prevention, partly because the tools are now available to do so.

Chronic diseases are preventable. Seventy-five percent of all heart attacks can now be prevented, particularly by modifications of lifestyle behavior. Ninety percent of all cancers may be preventable, depending upon the environmental factors. As early as 1910, Abraham Flexner in his seminal report commented at great length about the importance of preventive medicine. It is fascinating reading. I hope you will take it home with you.

It is interesting to quote something 70 years old and see how applicable it is today. He said the physician's function is fast becoming social and preventive rather than individual and curative. Upon him society relies to ascertain, and through measures essentially educational, to enforce the conditions that prevent disease and make positively for physical and moral well-being.

What happened? Fifteen years later, in 1925, Flexner published a retrospective analysis, and he noticed that while his report had revolutionized medical education, it had missed being adopted in the area of preventive medicine. He said: "Curiously enough, despite the increasing importance of preventive medicine, hygiene continues to occupy a decidedly subordinate position in the undergraduate curriculum."

The other report stressed the same kind of emphasis on preventive medicine in departments of medical schools throughout the century. In 1932, a report of the Association of American Medical Colleges stressed this, and then 13 years later, like Flexner, they came back and said it has not happened—what we need are separate departments of preventive medicine in every school.

They said there ought to be 4 percent of the curriculum devoted to disease prevention, at a very minimum, and they went on to talk about the integration of disease prevention into all clinical specialties. Other reports: in 1975 from the National Conference on Preventive Medicine; in 1978 from the Institute of Medicine; last year through the Surgeon General's Report; and finally, last December the Department of Health, Education, and Welfare submitted a report indicating the need to encourage and support the development of capabilities to provide training in health promotion, disease prevention, and other public health content in schools of medicine.

This long history of support for preventive medicine lies in stark contrast to the realities, where only 88 of 122 schools have departments, where less than 1.5 percent of the curriculum is devoted, to prevention, where, of the 48 accredited residency programs, the average number of physicians in them is four.

We see, then, throughout this a pattern of low Federal funding, lower now than it was several years ago, and that is in stark contrast to the suggestions of preventive medicine, of educators, of the medical schools themselves.

We support, therefore, very enthusiastically section 794(C)(a) (1), (2), (3), and (4). All four of these are equally important in providing stable generic support to departments in upgrading and updating the curriculum which is rapidly changing as research comes in in training researchers and teachers, and particularly in providing the support to a small number of needed specialists in preventive medicine who take on additional training, including an academic year.

Funding for this residency training is not available through patient care revenues as it is in other bedded specialties. It is particularly important that the Federal Government invest in the training of specialists in order to assure teachers, researchers, and those who can help to promote not the misinformation and excitement of health promotion in general, but who can help to figure out where our best investments are, how we can most effectively utilize scarce resources in promoting health and preventing disease.

It is a pleasure to appear before you and we are thoroughly supportive of your insights in this area.

[Testimony resumes on p. 487.]

[Dr. Peterson's prepared statement follows:]

Statement of the
American College of Preventive Medicine

Mr. Chairman, subcommittee members, ladies and gentlemen, my name is Kent Peterson, and I am the Executive Vice President of the American College of Preventive Medicine. I am pleased to have to opportunity to appear before you today to address issues raised by HR 6802, The Health Professions Educational Assistance and Nurse Training Amendments of 1980. The subject of manpower training in preventive medicine is especially important in light of our collective efforts to restrain the rise in health care costs in a time of rampant inflation in most sectors of our economy.

The American College of Preventive Medicine is one of 22 recognized medical specialty societies composed of over 2,000 physicians. Our members are teachers, researchers, administrators, and practitioners in preventive medicine, a specialty which has four sub areas of board certification: general preventive medicine, public health, occupational medicine, and aerospace medicine. Now in its 27th year, the College was founded to provide a forum for the advancement and dissemination of knowledge in the field.

Two of the College's highest priorities are our Prevention Policy and Education programs. The Prevention Policy program is responsible for formulating broad national policies for improving the nation's health and the advancement of prevention as a science, while our Education program provides support for undergraduate, graduate, and continuing education for prevention practitioners.

Prevention, though a small field, is dynamic in its concepts and goals. Preventive medicine is the branch of medicine that is primarily concerned with preventing physical, mental and emotional disease and injury, in contrast to treating the sick and injured. The paramount goal of this area of specialization is to promote and preserve individual health status. Additionally, it is concerned with the well-being of the community, and the efficient and effective management of scarce resources.

The distinct body of knowledge known as preventive medicine can be traced at least to 1913, when the first edition of Rosenau's Preventive Medicine and Hygiene was published. Since that time the body of knowledge has been extended and its focus has shifted in response to changing patterns in the incidence of disease. For instance, early in this century, preventive medicine was concerned primarily with communicable diseases, while today one major focus is on chronic conditions such as respiratory and heart disease, while another is health maintenance and enhancement.

Training and practice in preventive medicine build upon a diverse, multi-disciplined base. The "core" sciences of preventive medicine include epidemiology, biostatistics, environmental health, nutrition, clinical preventive medicine, the behavioral sciences, management and health care systems analysis.

As mentioned, preventive medicine practitioners are engaged in teaching, research, administration, and the delivery of personal health services. Teachers are responsible for instilling an awareness and knowledge of prevention in all medical students, through curriculum developed and taught by departments of preventive and community medicine, or through integrated curriculum in other clinical fields. Non-physician public health personnel are also trained by preventive medicine specialists within both medical and public health school settings. Researchers in the field are engaged in a wide array of activities, ranging from the study of risk factors and distribution of disease (epidemiology) to the design and evaluation of programs to promote health and prevent disease. Physician administrators occupy key positions in public and private settings, such as state and local health departments, and health maintenance organizations, where they are responsible for planning and implementing personal and community health services. Finally, practitioners deliver a variety of prevention services in the community setting, be it the workplace, school, or locality.

In 1979 *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* called for a second public health revolution in the United States. In conducting such a campaign, the importance of prevention and the role of the physician specialist in preventive medicine cannot be overstated. While the incidence of chronic diseases is on the rise, a growing body of knowledge documents our ability to intervene. This knowledge must now be translated into practice. Apart from the avoidance of human suffering, an investment in prevention promises the potential of tremendous returns in human productivity and in terms of cost savings.

PREVENTIVE MEDICINE AND MEDICAL EDUCATION

Our present model of medical education in the United States was largely shaped by a famous report, which included the following among its observations:

> "...The practitioner deals with facts of two categories. Chemistry, physics, biology enable him to apprehend one set; he needs a different perspective and appreciative apparatus to deal with the other, subtle elements. Specific preparation is in this direction much more difficult; one must rely for the requisite insight and sympathy on a varied and enlarging cultural experience. Such enlargement of the physican's horizon is otherwise important, for scientific progress has greatly modified his ethical responsibility. His relation was formerly to his patient - at most to his patient's family; and it was almost altogether remedial. The patient had something the matter with him; the doctor was called in to

> cure it. Payment of a fee ended the transaction. *But the physician's function is fast becoming social and preventive, rather than individual and curative. Upon him society relies to ascertain, and through measures essentially educational to enforce, the conditions that prevent disease and make positively for physical and moral well-being* (emphasis added)...[1]
>
> To the intelligent and conscientious physician, a typhoid patient is not only a case, but a warning: his office is equally to heal the sick and to protect the well..."[2]

That was written in 1910, in the "Flexner Report" on *Medical Education in the United States and Canada*, a report which otherwise revolutioned the course of medical education.

Fifteen years later, in a retrospective study of the 1910 report, Abraham Flexner wrote the following:

> "Curiously enough, despite the increasing importance of preventive medicine, consequent upon the advance of bacteriology and the clearer knowledge of the futility or limitations of many therapeutic measures, hygiene continues to occupy a decidedly subordinate

> position in the undergraduate curriculum; and even incidental treatment of the preventive aspects of disease, though increasingly common, is still far from general."[3]

In 1932 a Commission on Medical Education of the Association of American Medical Colleges (AAMC) made the following observation:

> "Medical education should emphasize to students the influences of urbanization, industrialization, and present day conditions of living which are important in the causation, treatment, and prevention of disease...it is important that the physician be acquainted with the social, economic, and other environmental factors which have an influence on the individual and his health."[4]

In 1945, a Committee of the AAMC, formed to investigate the teaching of preventive medicine and public health in medical schools, again found severe shortcomings in this area. Among other things, the report examined the importance of a distinct department of preventive medicine, as well as the necessity of increasing the proportion of the medical school curriculum devoted to prevention. Committee recommendations, which were approved by the AAMC Executive Committee, included:

"1. That the objective in each medical school be to provide a separate department of preventive medicine and public health and that for purposes of evaluating the organization for teaching preventive medicine and public health in any given school, the combination of preventive medicine and public health with some other department be regarded as unsatisfactory after July 1, 1948...

2. That there be set aside for the teaching schedule of the department of preventive medicine and public health, four percent of the total hours available in the curriculum of undergraduate medical education, and that after July 1, 1948, any medical school providing less that this amount be considered deficient in this regard...

5. That the various departments of the medical school in their respective fields, strive for the greatest practicable contribution in teaching the preventive aspects of disease; that in the highest degree possible, the teaching of preventive medicine and public health be integrated with clinical teaching,

> and that the greater part of the instructional staff in the department of preventive medicine and public health be given hospital and clinic appointments."[5]

In more recent years, both medical school curriculum and residency training in preventive medicine have been the subject of a number of studies. In 1975, a task force on Education and Training of Health Manpower for Prevention (National Conference on Preventive Medicine) found evidence of insufficient training of prevention within medical schools as well as shortages of specialty trained practitioners in the field. The task force recommended that federal health manpower legislation be enacted which would a) encourage a preventive emphasis on the basic curricula for health personnel b) provide career development support for training of teachers of prevention, and c) encourage projects to integrate prevention in programs to train primary health care personnel.

In 1978 these recommendations was confirmed by an Institute of Medicine report entitled A Manpower Policy for Primary Health Care. The report found that "...insufficient attention has been devoted to teaching and research in behavioral and social sciences, to the coordination and continuity of health care, and to clinical experience in outpatient settings." It therefore recommended that

> "Undergraduate medical education should provide students with a knowledge of epidemiology and aspects of behavioral and social sciences relevant to patient care."[6]

Last year the first Surgeon General's Report on Health Promotion and Disease Prevention was issued. In addition to proposing a strategy for the integration of prevention within our health care system, it discussed at length the manpower implications of such a strategy. Again, evidence of future shortages in the field of preventive medicine was cited, as well as an insufficient emphasis on prevention in the training of physicians.

Finally, in December 1979, the Department of Health, Education, and Welfare submitted a report to Congress on community and public health personnel. Among other things, this report contained the following recommendation for action by the Federal government:

> "Encourage and support the development of capabilities to provide training in health promotion, disease prevention, and other public health content in the curriculum of schools of medicine, osteopathy, dentistry, optometry, pharmacy, podiatry, veterinary medicine, and in schools offering preparation in the allied health programs."[7]

Clearly there has been long-standing consensus that our health care system, particularly the educational system, should place greater emphasis on prevention. This consensus, however, is in stark contrast to current realities:

* Of the nation's 122 medical schools, at last count only 88 have a department of preventive medicine or its equivalent. A number of these are today threatened with closure due to shrinking budgets. Others have already been forced to close down since the last count was made a year ago.

* Federal support for generic special projects in preventive medicine within medical schools has dropped precipitiously, from $1.1 million in FY 79 to zero in FY 80.

* It has been estimated that less than 1.5% of the total undergraduate medical curriculum is devoted to prevention, in contrast to the 4% recommended above by the AAMC.

* Of the 48 active accredited residency programs in preventive medicine, most have only a few funded positions

available. For 1978-79, the mean was 4.3 funded positions per program.

* Although it has been estimated that the annual output from these programs which is required to meet needs in the field is 160 graduates per year, currently only 70 complete training annually.

* Federal support for residency training has also declined in recent years. Whereas in 1973 $1.2 million was committed for this purpose, in 1978 and 1979 that level of support dropped to approximately $100,000. In FY 1980 approximately $275,000 will be made available for this purpose.

Although preventive medicine needs have been repeatedly stressed they have seldom been met. The reasons are obviously complex. Chief among these has been the minimal committment of financial resources within medical schools to departments of preventive medicine. Without these resources, existing departments, even where they do exist, are unable to develop the faculty, and hence the curriculum, fdr long-term impact upon medical student education. Without that impact, we are unable to recruit new physicians into the field, further exacerbating faculty development.

When medical students do express an interest in specializing in preventive medicine after graduation, they are faced with uncertain and fluctuating prospects for support during their residency training years. Many residency program directors resort to turning away prospective residents because the resources simply do not exist to support them. Government stipend support is particularly important for the preventive medicine resident because stipends cannot be provided out of patient care revenues as with other "bedded" specialties. An extra year of post-MD academic training is required for board certification. Preventive medicine residents are not hospital based during the remainder of their training, thus program directors cannot offset training expenses by providing services for remuneration. Finally, after graduation preventive medicine specialists generally occupy positions in the public health sector at salary levels which are much less lucrative than private practice, making repayment of educational loans much more onerous.

The current state of affairs has therefore led to extreme shortages in many preventive medicine areas. In addition to impacting on the delivery of public health programs and prevention research, this has obviously had an impact on the status of prevention within the medical school curriculum, thereby completing a vicious cycle. Without the required manpower pool, advancement will be impossible. Certainly if our health care system is to place greater emphasis on prevention, a change must be effected in the attitudes and behavior of medical students and physicians. Federal manpower policy must foster an integration of prevention principles within manpower education. The committment must be made now to develop the necessary manpower base to carry out this mission, and we applaud you both, Mr. Chairman and Dr. Carter, for your leadership in this regard.

We are therefore pleased that HR 6802 contains authority for support for both departments of preventive medicine and residency training in preventive medicine. These authorities will provide a stable base to attract talent and resources into this vital field. At the same time, it is disheartening to note that although the Administration has apparently adopted health promotion and disease prevention as a national priority, it has in its legislative proposal made no provision for development of the manpower base in preventive medicine which will be responsible for designing and implementing programs that respond to that priority.

The provisions contained in.Section 794(C)(a) of H.R. 6802 are all equally important. First, it is important to provide stable, generic support for the activities of the departments which is not tied to a specific purpose. In this way departments will have a resource to draw upon for innovative special projects and activities. Section 749(C)(a)(2), will support vital updating of the curriculum in the core knowledge areas of preventive medicine, because it authorizes projects to strengthen the preventive medicine interface with the other clinical specialties. Besides being a specialty area of knowledge, prevention also has multidisciplinary aspects which need to be integrated into other clinical specialties. Finally, support for programs to train teachers and researchers , as authorized in Section 749(3)(a)(4), is particularly crucial. These programs will expand a faculty base which has been drastically reduced in recent years because of diminished investment.

Confronting, as we do, a future of diminished resources which must be allocated among competing demands, it is important that we invest wisely with an eye to future returns. As health care costs have skyrocketed in recent years, alternative forms of cost containment have been examined. None offers more promise than prevention. Clearly, if the goals of our health care system is to assure optimal health at minimal cost, disease prevention holds an important key. HR 6802 will therefore provide the opportunity to unlock and apply knowledge which from as far back as 1910 has been generally recognized as being vital to our nation's health and well-being.

Footnotes

1 Medical Education in the United States and Canada, The Carnegie Foundation for the Advancement of Teaching, N.Y., N.Y., 1910, p. 26

2 Ibid., p. 68

3 Flexner, Abraham, Medical Education: A Comparative Study, MacMillan Co. N.Y., N.Y. 1925, p. 117

4 Final Report of the Commission on Medical Education, Association of American Medical Colleges, N.Y., N.Y. 1932

5 Final Report of the Committee on the Teaching of Preventive Medicine and Public Health, Journal of the Association of American Medical Colleges, Vol. 20, 1945

6 A Manpower Policy for Primary Health Care, Institute of Medicine Washington, D.C. 1978, pp. 77, 101

7 A Report on Public and Community Health Personnel, U.S. Dept. of Health, Education and Welfare, 1979, p. VII-8

Mr. **Waxman**. Thank you very much.

Mr. Gemmell, what is the position of your organization on the proposed midcareer training program?

Mr. **Gemmell**. The Bureau of Health Manpower, in its annual report to the Congress of which I have a copy here, guesstimated—because the data is pretty hard to get—that approximately 50 percent of the work force presently in the public health field requires retraining; that most of the people on-line now, if we are talking about high level people, that is the leadership cadre in public health, have been on the job now for 10 years.

Technology has changed. Health aspects have changed so much that they require short-term, intense retraining programs through continuing education, either weekends or longer or 3- or 4-week sessions in a university setting.

Some of the schools are gearing up to meet this demand, Mr. Chairman. We require Federal assistance, however, because this is a way of providing a community service. In schools of public health, like Dr. Peterson was talking about in preventive medicine and Dr. Filerman was talking about in health administration, we don't have a third party reimbursement system to recoup some of the costs incurred in providing these services, so we rely heavily on Federal support to promote these activities.

Mr. **Waxman**. HEW indicates public health is one area where a greater number of program graduates is needed. Can existing schools expand to meet these needs, or are additional schools going to be needed?

Mr. **Gemmell**. The present schools, Mr. Chairman, cannot handle the demand that we are projecting and that HEW is projecting for public health workers. Present schools have older facilities, and they need, if they are to meet this demand, funds to refurbish and modernize some of their facilities, especially in the classroom area.

To require them to develop an adequate teaching and research environment, right now they cannot do it without Federal support. It is tough to start a new school of public health, so we are looking for refurbishment and modernization-type funds for the present schools to meet this growing demand.

Mr. **Waxman**. Dr. Filerman, in your formal statement, you recommend the development of new project authorities for curriculum development in a variety of settings. Could you expand on that interest and indicate if you envision more than one-time grants to institutions for such purposes?

Dr. **Filerman**. The problem is that the state of the art keeps changing. We keep building on previous foundations. I would not suggest that we need continuing grants of a project nature to carry on the same kinds of projects. But, for example, we know that one of the greatest needs today is to improve the teaching and financial management.

We also know that there is a very strong need to increase teaching in community-oriented epidemiology, two very fundamental areas. When we have brought the programs up to a certain minimum state of the art and training capacity in those areas, there will be another agenda, probably quality assurance or improved health planning.

So what we need is a flexible project grant authority which can be responsive to those kinds of changing needs, not continual support.

Mr. **Waxman**. Are you talking about one-time grants for startup in these areas, or a continuous grant program that would be flexible enough to meet these needs?

Dr. **Filerman**. In the project grant area, we are talking about funds which are primarily designed for cutting edge innovation developmental activities. In what we call capacity development grants, which are the more permanent variety, those are the grants which make sure that the on-the-ground fundamental critical mass of skills are there and paid for.

But what we have recommended is essentially a continuation of the formula started by the committee 3 years ago of requiring a certain level of non-Federal support first, not Federal first dollars but Federal carrots, if you will, to bring out a stronger base of support for the core of the program operation from the institution, from the community in which it is embedded. That has worked very well.

Mr. **Waxman**. Dr. Peterson, can you please tell us something about the content of residency training programs in preventive medicine?

Dr. **Peterson**. Yes. As required by the American Board of Preventive Medicine for certification in the specialty, there are four components. First there is a clinical component. Preventive medicine is a clinical specialty and its practitioners must have at least 1 year of clinical training in an internship or residency.

A second year is academic training, and it is here where the tools I mentioned earlier require classroom study which is different from that in any other specialty of medicine, the study of epidemiology, of biostatistics, of management, of environmental health, as well as clinical preventive medicine.

This usually occurs in a program either in a school of public health or its equivalent master's degree program offered by the department of preventive medicine.

A third year is a closely supervised year of residency training and experience either in general preventive medicine, public health or occupational medicine. And fourth, for certification there is a period of practice under supervision which is required.

It is these unique opportunities, particularly the academic component and the carefully supervised residency component, which traineeships would support.

Mr. **Waxman**. What do you think could be done in medical school to stimulate an interest in preventive community medicine?

Dr. **Peterson**. Right now there is a great groundswell of interest on the part of students. Last week in Philadelphia at the American Medical Association, the cry of prevention and wellness sprang up loudly on the part of medical students. The interest is there.

Many medical schools have the capacity, and in those schools with large departments of preventive medicine or where there are schools of public health, there is the teaching resource available. But many other schools simply do not have competent faculty.

Internists, surgeons, and primary care physicians need to have a certain level of skills and competence in helping individuals to improve their own health and in assessing risks, but it requires more than a good internist or a good family practitioner to teach that. That is why we feel so strongly that your inclusion of departmental support is so essential.

There needs to be a core of faculty who do research and work throughout all of the departments to inculcate prevention into the training of all physicians.

Mr. **Waxman**. Mr. Gemmell, how are schools of public health responding to the need to assess the effect of environmental pollution on human health?

Mr. **Gemmell**. Mr. Chairman, environmental health problems are going to probably occupy most of the attention of public health workers in the United States in the eighties and nineties. In the fifties and sixties and the early seventies, even when Dr. Hardy was a health officer in Birmingham, we didn't spend a lot of time on environmental health. We spent a lot of time on infectious disease control.

But now most health workers spend most of their time on environmental health issues. Johns Hopkins University School of Public Health in the last 3 years has increased their faculty in environmental health from 17 to 50 and expect to double that in the next 5 years.

These are the kinds of things we are being faced with. As microbiology was in the medical schools in the thirties and forties, environmental health will be to the schools of public health in the eighties and nineties Mr. Chairman. It is a big growth area.

We look forward to working with you in this bill to make sure there is adequate support for those programs, which we hope there will be.

Mr. **Waxman**. I hope so, too. I have been told that only about 11 percent of the money for formula grants for trainingships for schools of public health, section 748 of the Public Health Service Act, is allocated for programs in environmental health. Is this amount adequate or is more money needed to train indivduals for a career in environmental health?

Mr. **Gemmell**. As a flat statement, Mr. Chairman, no it is not adequate to train individuals in environmental health. The 11-percent figure is because you have to split up that money according to a congressional mandate to other areas, like biostatistics, epidemiology, nutrition, maternal and child health, biostatistics and health administration. So that is the reason.

I believe, if I recall, 2,000 students last year in schools of public health received some sort of Federal support in the trainingship area, and about 200 of those students were environmental health specialists. So that is a very small amount. We need to increase this pot in the near future.

Mr. **Waxman**. In your statement you commented on the adequacy of the level of funds authorized over the past few years for special projects for schools of public health, section 792 of the Public Health Service Act. How much money would be required to help schools of public health develop new and responsive programs in environmental health?

Mr. **Gemmell**. Mr. Chairman, we would like to survey the schools on that question. I would not like to mislead you and tell you either we think there is a great demand, but I would much rather survey the schools and get back to you with the information as soon as possible.

But given the Johns Hopkins study about which I was talking to the dean last Friday that is increasing his faculty from 17 to 51 and then expecting to double it in the next 5 years, that in itself is a great indication of need. But let me get back to the committee with some specifics on that question, Mr. Chairman, if you do not mind.

Mr. **WAXMAN**. Fine. We will hold the record open for that information and any other information that any of you wish to submit to us. Thank you for your testimony. We appreciate the contribution you have made to this hearing.

[The following letter was received for the record:]

APPENDIX: Some Studies on the Cost Effectiveness of Pharmacists in Clinical Roles

Pharmacy practice achievements, as they relate specifically to cost containment, primary care, and access to health-care services, involve pharmacists' expanded roles in ambulatory, acute, and extended care.

One of the best examples of the cost effectiveness of the pharmacist in these roles is a pharmacist-conducted training program that teaches patients to self-administer certain parenteral medications at home. Selected patients of the Ohio State University Hospitals are trained to self-administer calcitonin, injectable analgesics, antihemophilic factor, cytarabine and parenteral hyperalimentation solutions, thus minimizing the cost of outpatient clinic, physician, or home nurse visits. (1) Financial data based on one year's experience with this program indicate that savings far outweigh costs. For one patient alone, a hemophiliac receiving Factor VIII, savings were more than $20,000 in the first year. (2) The pharmacists' professional services under this program are reimbursed by Blue Cross of Central Ohio; approval of such payment by a third party is viewed as a major step in recognizing the cost effectiveness of the pharmacist's clinical role. Other pharmacy programs to train patients in the home administration of total parenteral nutrition have been reported. (3)

Another example of reimbursement for clinical pharmacy services is a program in a medium-size community general hospital whereby third parties reimburse, on the basis of documented costs, for growth hormone home instruction, patient consultations and visits, and pharmacokinetic consultations by pharmacists. (4)

Several published reports indicate that pharmacists' therapy management or monitoring of patients with chronic diseases such as hypertension or diabetes may result in cost savings through improved treatment outcomes and better utilization of health-care personnel. One report described the effect of patient-oriented pharmaceutical services on treatment outcomes of diabetic patients who were randomly assigned to study and control groups. (5) Patients whose therapy was monitored and who were counseled by a pharmacist showed improved symptomatology, required significantly fewer changes in therapeutic regimen, and had a lower incidence of hospital admissions and physician contacts as compared to patients in a control group. In another study, patients with essential hypertension revealed significant improvement in knowledge of the disease, compliance with prescribed therapy, maintenance of blood pressure within the normal range, and the requirement of physician follow-up when clinical services were provided by a pharmacist. (6) A study funded by the National Center for Health Services Research and conducted at a Public Health Service Indian hospital determined the effectiveness of a pharmacist in the management of patients on long-term drug therapy. Working under detailed chronic care protocols and defined health parameters for specific chronic diseases, more efficient utilization of both pharmacists and physicians was achieved without sacrificing quality of care. (7) Although the three studies mentioned above did not specifically address cost savings, they suggest substantial savings through a reduction in hospitalization or physician visits.

In a cost-benefit study conducted in an outpatient clinic of a large medical center, the average prescription cost for patients who received only traditional pharmacy dispensing services was more than 2.5 times that for patients whose therapy was monitored by a pharmacist. (8) The difference in cost was attributed, in part, to the use of patient medication profiles, the selection of less expensive drugs when possible, and the elimination of drug duplications through coordination of therapy prescribed by more than one physician.

Mr. WAXMAN. Our final witnesses for today's hearing will be Dr. Wendell T. Hill, Jr., dean, Howard University College of Pharmacy, and Mr. Lee W. Smith, executive director, Association of Schools and Colleges of Optometry.

We would like to welcome both of you to this hearing. I believe you have prepared statements, which we will have in the record in their entirety. We would like to ask you to summarize your testimony to us in about 5 minutes.

Dr. Hill.

STATEMENTS OF WENDELL T. HILL, JR., PHARM. D., ON BEHALF OF AMERICAN ASSOCIATION OF COLLEGES OF PHARMACY, ACCOMPANIED BY JOHN SCHLEGEL, ASSISTANT EXECUTIVE DIRECTOR; AND LEE W. SMITH, M.P.H., EXECUTIVE DIRECTOR, ASSOCIATION OF SCHOOLS AND COLLEGES OF OPTOMETRY

Dr. HILL. Mr. Chairman, we would like to commend Congressman Waxman and the cosponsors of H.R. 6802 for recognizing the needs of our schools, even in these difficult times. We would also like to recognize Senator Kennedy's fine bill and part of Senator Schweiker's bill.

I would like to spend most of my time here addressing the administration bill, H.R. 6800, because I feel it presents such a serious threat, both to our colleges and to the public interest. As you know, H.R. 6800 would remove almost all support for VOPP schools.

The elimination of entitlement institutional support would have disastrous effects on our clinical pharmacy programs. This subcommittee is aware of the contributions, both in cost containment and in patient welfare, made by clinically trained pharmacists. Some documented studies are included in the appendix to this statement.

This clinical training has been costly to our schools. We could not have accomplished what we have without past capitation support, and it is difficult to see how we can keep up our programs at a meaningful level without continued support.

In a survey our association conducted 1 month ago, our schools were asked what effect elimination of capitation support would have on the retention of their young, innovative but largely nontenured clinical faculty members. Only 7 schools out of 72 replied that the elimination of capitation would make no difference, that all clinical faculty would be retained.

Some of these schools, however, wrote in that the cessation of capitation payments would prevent them from hiring much-needed additional clinical faculty. One of these schools wrote in that it would retain its present faculty but that it would have to raise tuitions if capitation support ceased.

Of the other schools, responses indicated that about half—49 percent—of their clinical positions would probably not be retained and about half—51 percent—would be retained. Thus, if institutional support is eliminated, the threat to our schools' clinical programs is real and substantial.

Another problem with the administration bill, and partly with H.R. 6802, is the emphasis placed on the role of the National Health Service Corps, which is virtually closed to pharmacy students. We understand that the corps scholarship program exists to assure an adequate supply of health professionals in underserved areas.

We also admit proudly that pharmacists are among the best distributed and most accessible of all health professionals. The point we wish to make is that the well-distributed pharmacists are those performing in the traditional dispensing role, not clinically trained pharmacists performing in the new consulting and direct patient care role. This is true for the following reasons.

First, there are relatively few consulting and direct patient care pharmacists in the country because our colleges have only been turning out clinically trained pharmacists for about 10 years.

Second, what few there are, are distributed mainly around academic centers because (*a*) physicians and consumers outside the areas where clinical pharmacists train are simply not aware of their abilities in cutting the use of unneeded drugs and in deterring adverse reactions, thereby preventing unnecessary illness and hospitalization; and (*b*) the lack of reimbursement schemes has prevented these professionals from venturing into the community as practitioners apart from institutions where they are salaried or hired as consultants.

It seems to us that significant, large-scale participation by nondispensing, clinically trained pharmacists in the National Health Service Corps scholarship program could go a long way in addressing these distribution problems. We know that Congress is aware of what our recent graduates are accomplishing and approves of it heartily.

However, these professionals will not realize their full potential, both in helping people and in controlling costs, until they become more widely known. The National Health Service Corps is certainly an appropriate instrument for bringing clinical pharmacy to the community.

One program we would like to see added to H.R. 6802 is a federally supported clinical pharmacy residency program. Currently postgraduate residencies are being accredited in hospitals and community facilities in many important areas: General clinical pharmacy, ambulatory and primary care, mental health, geriatrics, toxicology and poison control, pharmacokinetics, oncology, pediatrics and IV therapy/nutrition. Unfortunately for us all, a sufficient number of residencies does not exist to accommodate even half of the highly qualified applicants interested in them.

I would like to conclude with this thought. One out of every seven hospital patient-days in this country is accounted for by drug reactions, at an annual cost of $3 billion. Fiscal constraints notwithstanding, this is a most inappropriate time to withdraw Federal support for the clinical training of our Nation's pharmacists.

Thank you for this opportunity to present our views.

[The appendix to Dr. Hill's prepared statement follows:]

A report of a study in nineteen hospitals indicated that clinical pharmacy services combined with a unit-dose medication system could reduce overall costs by \$.79 to \$1.25 per patient day. (9) This finding assumes added significance when considering that the American public is hospitalized in short-term general hospitals for approximately 275 million inpatient days per year.

Participation by pharmacists in medical rounds in a 250-bed pediatric hospital resulted in cost savings of \$.54 per patient day solely through elimination of medication waste due to late drug order changes. (10) Assuming 90 percent occupancy in this hospital, the total yearly savings would be nearly \$45,000. In an unpublished study conducted at the University of California Medical Center in San Francisco, a clinically trained pharmacist who monitored total parenteral nutrition therapy in the surgical service of the hospital was able to effect a 24 percent cost savings, representing a net savings of \$14,000 in one year. (11) Another report indicated that clinical pharmacy services were responsible for reducing the hospital stay, by one day, of 20 percent of 130 internal medicine patients. (12) By extrapolating the net cost of the pharmacists' services to a yearly basis, the savings for just the two internal medicine wards would be more than \$20,000. A pharmacy program of discharge medication interviews in another university hospital resulted in substantial dollar savings for patients and was deemed to be cost beneficial. (13)

A study carried out in four skilled nursing facilities, one of which served as a control, demonstrated that clinical pharmacy services resulted in estimated savings of \$80,000 per year for 300 patients (\$.73 per patient day) through reduction in the use of inappropriate or unnecessary drugs and prevention of adverse drug reactions. (14) Clinical pharmacy services provided to 25 Medicaid patients in a skilled nursing facility in Washington state resulted in savings of about \$6 per patient month through reduction of unnecessary drug use. Projected to all such facilities in the state, the net savings to the Medicaid program would be \$747,000 per year. (15) Drug regimen reviews performed by pharmacists in six skilled nursing facilities and one institution for the mentally retarded resulted in a reduction of 0.9 to 2.44 prescription orders per patient per month. Extrapolation of the dollar savings to all Medicare and Medicaid skilled nursing facilities in the country would yield net savings of \$3.2 million to \$37.2 million per year. (16) Several reports of drug-related problems in nursing home patients, and of the positive effects of pharmacist intervention to alleviate these problems, have resulted in a call for expanded pharmacist involvement in drug therapy review in extended care facilities. (17)

These selected reports are cited to demonstrate that direct patient care activities of the pharmacist--activities which are emphasized in contemporary pharmaceutical education--have had and can continue to have a decided impact on national health priorities. We have not attempted to demonstrate how more traditional, yet still important, activities of the pharmacist in drug procurement and distribution (e.g., the hospital formulary system and unit-dose medication systems) can effect cost savings in health care. Cost savings and other benefits of drug product selection by the pharmacist, as well as of unit-dose drug distribution systems, have been well documented elsewhere.

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May 22, 1980

The Honorable Henry A. Waxman
Chairman
Subcommittee on Health and the Environment
House Commerce Committee
2145 Rayburn House Office Building
Washington, D.C. 20515

Dear Mr. Chairman:

On March 24, the Association of Schools of Public Health testified before your subcommittee on the extension and modification of P.L. 94-484, the "Health Manpower Act". One question that was asked after presenting our testimony was the approximate number of trained environmental and occupational health personnel needed to operate our current national and local public health programs.

After looking into the matter (e.g., contacting the Deans, EPA and HSS), we have concluded that we lack the tools necessary to estimate public health manpower needs in the future. However, the July 1979 Surgeon General's report ("Healthy People") said that although there is a lack of public health manpower data,* there are definite shortages of certain specialized disciplines such as epidemiologists, biostatisticians, occupational and environmental health workers and health service administrators. The overwhelming majority of these professionals are trained in Schools of Public Health.

For these reasons, Mr. Chairman, we request that a study be conducted on the impact of federal programs (Toxic Substances Act, Resource Conservation and Recovery Act, Clear Air Act, Clean Water Act, among others) on the demand for environmental and occupational health manpower.

Your thoughtful consideration of our request would be appreciated.

Sincerely yours,

M Gemmell

Michael K. Gemmell
Executive Director

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*Reasons for the lack of data are several, such as a lack of uniform and fixed definitions and requirements for employment, methodological problems and high costs of gathering information.

Mr. WAXMAN. Thank you very much, Dr. Hill.

Mr. Smith, we are pleased to have you with us.

STATEMENT OF LEE W. SMITH, M.P.H.

Mr. SMITH. Mr. Chairman, I am Lee W. Smith, executive director of the Association of Schools and Colleges of Optometry. The association's 13 member institutions in the United States are dedicated to training doctors of optometry necessary to meet the primary vision care needs of the American public. We represent a limited national resource and are vitally interested in the legislation under consideration today.

We have reviewed H.R. 6802 introduced by you and others on March 12, 1980, which makes certain amendments to existing legislation in support of education of health professionals. We are pleased to have the opportunity to provide our comments to this proposal and to suggest additional amendments to address present and future issues in the national interest.

H.R. 6802 would extend the National Health Service Corps program and its related scholarships. This program is designed to provide for unmet health care needs in health manpower shortage areas. Unfortunately, the administration of the National Health Service Corps has not addressed the unmet vision care of such areas even though extensive shortages exist.

Presently there are 248 designated counties requiring over 351 practitioners. We urge the committee to include specific language to include optometry for primary vision care needs and that scholarships be allocated in proportion to this shortage. With the high cost associated with Federal employment and utilization of health personnel, we support the bill's intent to have obligated health personnel serve in private practice circumstances. We recommend, however, that more specific incentives be included in the legislation to make private practice preferable.

The Association of Schools and Colleges of Optometry contends that the present schools cannot produce the needed number of practitioners for the future. There is also a significant geographic disparity with only 13 schools. This results in educational limits for many possible students. We are therefore supportive of continuation of construction assistance as provided under section 720. This, combined with continuation of startup grants under section 788, will provide the opportunity for development of the needed additional facilities to meet future requirements.

The bill would continue the health professions loan programs. Our students have participated in the health professions student loan program as the primary source of loans for their educational needs. With the high cost of education, the availability of low cost loans is of the highest priority. We support this proposal.

Scholarships for Students of Exceptional Financial Need under section 758 have been employed by our schools to encourage minorities and other disadvantaged to pursue optometry as a profession.

H.R. 6802 proposes a new institutional assistance program which for optometry would authorize approximately $450 per student per year. Our educational programs are in need of Federal support. If fully supported by appropriation, the amount would be $450 and perhaps acceptable.

The eligibility requirement of increasing class size is not, in our opinion, beneficial, however. While there are needs for additional optometrists, expansion of present facilities to accommodate more students would strain our resources and not solve the geographic problem. The selection of 50 percent of out-of-State students is also of concern and should be removed. There are other objectives that could be substituted for this in qualifying for assistance.

Optometry has been supportive of the Area Health Education Center concept. We have not, however, been actively included in any of the existing projects. We urge the committee to incorporate grant incentives into the legislation for the inclusion of optometry and other professions in these center activities.

The Association of Schools and Colleges of Optometry have observed the Graduate Medical Education National Advisory Committee work. It is our opinion that it has the potential of making significant contributions regarding the supply and utilization of physicians. We also believe that the committee should include in its study the effective development and utilization of other professions providing primary care services. Therefore, we would encourage the committee to include the relation of physicians to nonphysician providers in the charge to GMENAC. In this regard, section 712(a)(1)(3) should be amended and we would specifically ask that it include an optometrist member in the advisory committee membership.

Mr. Chairman, late last year our association developed an issues paper on health manpower needs and suggests Federal initiatives to address these issues. We are pleased to make a copy of this paper available for the committee's consideration.

We congratulate the committee on moving forward with health manpower legislation. I am available to answer questions you may have.

Mr. WAXMAN. Before I ask for questions, I want to acknowledge the presence of a delegation from the California Medical Association with us today. They are in Washington to meet with me and other members of the California medical delegation to make sure we are watching the interests of the California physicians.

They are also here for another very important reason, and that was to honor the ranking Republican of our subcommittee, Dr. Tim Lee Carter, who today was saluted by the California Medical Association. I want to ackowledge their presence and welcome them to our hearing.

Let me ask each of you what percent of your operating budget is provided by capitation. Dr. Hill?

Dr. HILL. I would like to refer to the association's representative.

Mr. SCHLEGEL. My name is John Schlegel. I am the assistant director of the American Association of Colleges of Pharmacy. Last year when the capitation support to the schools was somewhat larger, about 20 percent more, it represented about 11 percent of our operating budget.

So now it would be somewhat less than 10 percent. I would caution that that median figure is a little dangerous because I think actually we have almost a bimodal distribution. We have many schools in which it represents substantially more of the budget, and we have some schools, primarily State schools, where it may represent, in fact, substantially less than the 10-percent budget.

And the added caution I would add is schools very often, where it represents more, do not have the opportunities for replacement money such as State legislatures.

Mr. WAXMAN. What percentage of your students receive Federal financial aid?

Mr. SCHLEGEL. That we would have to get back to you on, Mr. Chairman.

Mr. WAXMAN. We will hold the record open for that information. What do you consider to be the current cost of educating a pharmacist?

Mr. SCHLEGEL. The figure we have been using is the Institute of Medicine study back in 1973 and 1974. I don't know the precise figure, but we will get back to you on that.

Mr. WAXMAN. Dr. Hill, what would be the program content of clinical pharmacology residence?

Dr. HILL. The program content would train pharmacists, centrally, along with clinical pharmacologists on the medical side to assist in the study of drugs, and also on a day-by-day clinical activity, it has to do with detection and prevention of adverse drug reactions, the efficient and effective use of drugs, the selection of the most cost-effective and the most effective drugs in the best dose.

Mr. WAXMAN. Mr. Smith, what percentage of your operating budget is provided by capitation?

Mr. SMITH. We have presently less than 10 percent. It is about 9.2 percent across the board. However, this varies considerably because approximately half of our schools are private, versus the other half being within public institutions. It does represent significantly less of the total cost of private education.

You had asked a question as to the proportion of students under Federal support. I don't have that information available but I would provide it for the record. A number of our schools have over the last few years moved to what is known as full-cost tuition, in which the full cost of the educational portion of the operation and management of the schools has been placed as the tuition level to the student and actually then reduced by the amount of other sources of funds such as capitation.

Within that, I can then identify to you what we consider to be the actual costs. One of our schools which has gone to this level this year is just short of $9,000. Another is at $8,400. And it is within our private schools that this calculation can best be made.

Within the public school areas, of course, so many services come from other parts of the university other than the school. That determination is somewhat limited. However, the University of Alabama studies have shown that within their school, approximately $12,000 per year per student is the level. That takes into account a number of other kinds of activities and research in which they may be engaged.

[The following information was received for the record:]

A review of our data for the school year 1978–79 indicates that approximately 58 percent of our students are receiving support in the form of loans and scholarships. This figure is significantly higher for the private schools of optometry than those supported by the various states. The range is 26 percent to 92 percent.

Of the total funds used to support students under loans and scholarships approximately 35 percent is from Federal sources or is Federally insured. It should be noted that the students borrowing privately are not included in our data.

Mr. **Waxman**. Thank you very much.

Dr. Carter.

Mr. **Carter**. Thank you, Mr. Chairman.

I want to congratulate the chairman on his work and the fact that the California delegation is here today. I am deeply pleased that they are here and very thankful for the honor they have bestowed upon me.

I have several questions which either or both of you might want to answer. Do you generally agree or disagree with HEW's projected supply and requirements for your profession in 1990? I believe the only field in which HEW predicted a shortage was podiatry.

Dr. **Hill**. I would like to say, without any specific data, which we would be happy to get to you later, that we project a severe shortage of the clinical pharmacist. Chairman Waxman asked earlier about the residency. I did not comment on what I can see as the future activity of pharmacists in relieving the health care personnel shortage.

A clinical pharmacist model could be similar to, say, the PT occupational therapist or dietitian, where the physician would write a generic prescription for a drug and the pharmacist would then have the responsibility of carrying out the medication demands of the patient as decided by the physician, who would monitor the progress of the patient, and the physician would see the patient on a periodic basis he would determine.

This would greatly expand the health manpower and would provide a very highly skilled drug expert in the area. The numbers for this kind of involvement of pharmacists, I don't know they have been determined. I would ask my associates if they have some numbers.

Mr. **Schlegel**. Yes, Mr. Chairman. We are concerned about the projections even if we do accept them as being accurate. We have moved to enrolling many, many more women in our programs. Our student body is now 43 percent female. We do not know what impact this is going to have on full-time equivalent practice. We don't have a good enough track record.

So although the numbers may be absolutely correct, we are not quite certain what impact this is going to have on service delivery.

Mr. **Carter**. What is your response, if you please, sir.

Mr. **Smith**. We are not in agreement with the figures. Based upon our studies, our schools should be able to produce approximately 1,600 graduates per year by the year 1990. We presently are graduating approximately 1,100. That is in order to maintain the present practitioners who will exit from practice during the period 1990 and at the same time begin to address the unmet health manpower need.

The geriatric population is increasing. With a large increase then in its demand and need for vision care in persons 60 years and older, 95 percent are in need of consistent vision care services. So we are not in agreement with those figures.

Mr. **Carter**. I have been pleased to support these programs over the years. As I recall the administration's explanation for not awarding many National Health Service Corps scholarships to the veterinarians, optometrists, pharmacists, and podiatry students, was in part because these so-called VOPP students are easier to encourage to go to underserved areas voluntarily than are physicians or dentists.

Do you agree?

Mr. SMITH. Yes; I have to agree that the history of optometry's geographic distribution has been an excellent one. Unfortunately, the ever-increasing indebtedness of our young graduates has forced them to consider the highest return of where can they practice and meet that obligation of indebtedness.

In our opinion, that will have a seriously adverse effect on the good geographic distribution we have had in the past.

Mr. CARTER. What is the average cost per year, total cost, tuition and everything, for a pharmacy student, if you please, sir?

Mr. SMITH. In optometry?

Mr. CARTER. Yes. Excuse me.

Mr. SMITH. It would range between $16,000 and $20,000 per year.

Mr. CARTER. $16,000 to $20,000.

Mr. SMITH. That is living costs, equipment, and laboratory fees.

Mr. CARTER. Yes, sir. How many years does the degree require?

Mr. SMITH. It is a 4-year requirement for the professional degree.

Mr. CARTER. What do you think about our interest rate? Do you think it should rise as the price of the lending rate of the City Bank of New York, which is 19 percent, I believe?

Mr. SMITH. If that should occur, Dr. Carter, we are convinced, of course, it will directly affect the cost of health care. For that to occur because of interest rates rather than additional service would not be in the best interest of the public.

Mr. CARTER. Would you call it a disaster to optometry?

Mr. SMITH. I think it will be most difficult for us to attract anyone but the rich into our schools.

Mr. CARTER. What percentage of your students require financial aid?

Mr. SMITH. By the time they graduate?

Mr. CARTER. Yes, sir.

Mr. SMITH. I would say approximately 70 percent of our graduates have had financial aid by the time they graduate.

Mr. CARTER. Dr. Hill, do you have numbers on that?

Dr. HILL. I don't have specifics on a national basis, but I can tell you in our university, close to 100 percent of our pharmacy students require financial aid. I could not quote what takes place in other parts of the country.

Mr. CARTER. What do you think about this high interest rate as it would affect students interested in entering your fields? Under the HEAL program the interest was limited to 12 percent.

Dr. HILL. Even 12 percent is a higher interest rate than the student would have to bear if he has a loan that covers 4 years. If he has $10,000 in loans or $2,500 in loans over a 4-year period, if the interest accumulates while he is attempting to pay it off, this becomes a large burden.

Mr. CARTER. I believe it is estimated that a significant majority of medical students borrow. The total cost at the end of the time of payback including residency would be $140,000 at the 12 percent rate. With the interest rates going up as they are, I doubt that we will see the projected increase in any field.

I would like to see the interest rates come down. A strong Democrat by the name of Wright Patman from Texas, who said that the interest rate is what the Director of the Federal Reserve makes it. I am inclined to agree with him. I would like to see those rates come down to make it easier for our young people to go to school.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Dr. Carter, and thank you gentlemen for your testimony. We appreciate it.

This concludes our hearing for today. Hearings originally scheduled for tomorrow have been canceled. We will continue Wednesday, March 26, at 2 p.m. in room 2218, and on Thursday morning at 10 a.m. in room 2218.

Thank you.

[The following letter was received for the record:]

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March 26, 1980

The Honorable Henry A. Waxman, Chairman
Subcommittee on Health and the Environment
Committee on Interstate and Foreign Commerce
U. S. House of Representatives
Washington, D. C. 20515

Dear Mr. Chairman:

We would again like to thank you for the opportunity to testify on March 24 regarding health manpower legislation, and for this opportunity to further address some of the questions you asked at that time.

1. WHAT PERCENTAGE OF PHARMACY STUDENTS ARE ON FINANCIAL AID? WHAT PERCENTAGE RECEIVE SOME TYPE OF FEDERAL AID?

   Results of an AACP survey taken two years ago indicate that on the average, 47% of our students receive some sort of financial assistance and 30% receive federal aid. This does not include loan money received from families.

   Please note that because of pharmacist's salary is relatively modest (under $20,000 per year upon graduation, under $30,000 per at the peak of his or her career), charging high tuitions is not a feasible alternative for our schools. It is, in fact, precisely because of this lower earning potential that pharmacy students cannot afford the large indebtedness of other health professions students. Even though the current pharmacy curriculum places substantial intellectual and time demands on students, fully 80% find it necessary to finance their education in part through part-time employment.

2. WHAT IS THE COST OF PHARMACY EDUCATION?

   Our estimate of the cost per student for the 1980-81 academic year is $7,000. This was derived from the Institute of Medicine's 1972 figure of $3,550, which was then inflated by the Consumer Price Index (a 13% average-to-average inflation rate was used to project the CPI for the current year).

   We would like to emphasize that this figure does not take into account the significant rise in educational cost due to the introduction into the curriculum of clinical pharmacy programs. When the IOM study was undertaken, only about 15% of the studies of final year pharmacy students was clinical in nature, while today that component represents 55% of the senior year program. Thus, the $7,000 figure represents only inflation, and not this significant increase in costs due to the increase in the clinical component of the curriculum.

3. AREN'T SUFFICIENT VOPP PRACTITIONERS ALREADY ATTRACTED TO UNDERSERVED AREAS THROUGH THE MARKET MECHANISM?

We would like to stress a point made in our testimony before the Subcommittee. Yes, significant numbers of traditional, dispensing pharmacists are located in underserved areas. No, significant numbers of clinically trained pharmacists performing in the new consulting and direct patient care role are not attracted to such areas.

Incidentally, we do not wish to belittle the importance of the role of the traditional community pharmacist in providing a service and keeping health care costs down through supplying and counseling about prescription and nonprescription drugs.

However, our recently trained pharmacists performing the newer clinical pharmacy activities are few in number, since these programs have been widely offered only in the past several years. The few that exist tend to cluster around academic centers, where their abilities are known and appreciated, and where reimbursement for these services is not a problem.

Bringing clinically trained pharmacists to rural and inner city areas should be a priority of the NHSC for many reasons, not the least of which is that they can complement and enhance the care provided by physicians. A perfect example of this is the primary care function that pharmacists in the US PHS Indian Health Service are performing. Once the physician diagnoses and stabilizes a patient, the pharmacist is responsible for followup visits. He or she assesses the effectiveness of drug therapy, orders laboratory tests as needed and authorizes some prescription refills. He or she may adjust medication dosages and even prescribe using protocols developed by the interdisciplinary team.

Another good example of clinical pharmacists "extending" the services of physicians in shortage areas is the work being done by our new psychiatric pharmacists. These specialists are clinical pharmacists who further their education in psychopharmacology, psychopathology, psychotherapy and interviewing techniques; in some places they are performing a role that, in their absence, could be filled only by a psychiatrist. In a recent three-year study at a rural community mental health center in Georgia, where psychiatrists were often inaccessible or unavailable, a psychiatric pharmacist routinely stabilized and maintained schizophrenic patients on their individualized drug regimens - out of the hospitals, functioning in the community.

I hope this response is helpful. I would be pleased to supply any additional information and to work with the Subcommittee on the development of legislation.

The nation's seventy-two colleges of pharmacy are aware of and appreciate your support.

Sincerely,

John F Schlegel

John F. Schlegel, Pharm.D.
Assistant Executive Director

JFS:mb

[Whereupon, at 3:05 p.m., the hearing was adjourned to reconvene Wednesday, March 26, 1980.]

HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE AND NURSE TRAINING ACT OF 1980

WEDNESDAY, MARCH 26, 1980

House of Representatives,
Subcommittee on Health and the Environment,
Committee on Interstate and Foreign Commerce,
Washington, D.C.

The subcommittee met, pursuant to notice, at 2 p.m., in room 2218, Rayburn House Office Building, Hon. Henry A. Waxman, chairman, presiding.

Mr. Waxman. The subcommittee will come to order.

This afternoon we continue our hearings on health manpower by examining two additional aspects of this important area of public policy, the questions of foreign medical graduates and the geographic distribution of physicians in this country.

In adopting Public Law 94-484 the Congress embraced a policy that this Nation needs to depend on its own medical school graduates as a principal source of its medical care and that we would no longer be responsible for the physician "brain drain" from other nations which had become all too frequent in the past. Today we will review the effects of these decisions and consider modifications which may be necessary in this policy. The Department of Health, Education, and Welfare, the American Medical Association and the Association of American Medical Colleges have already addressed this policy area in their testimony. Today we will hear from two additional witnesses who are responsible for carrying out the mandates of the Congress.

In addition, we will receive for the record a statement from the city of New York concerning their continuing need for foreign medical graduates and their graduate medical training programs. They had planned to be with us but were unable to join us for the hearing and their statements will be made part of the record.

[Testimony resumes on p. 528.]

[The statement referred to follows:]

STATEMENT OF
THE NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

PROPOSAL FOR REDUCING RELIANCE ON FOREIGN MEDICAL GRADUATES

SUMMARY

As the principal provider of health care to New York City's poor, near-poor and inner-city residents, the Health and Hospitals Corporation and its seventeen public hospitals are heavily dependent upon the physician services of foreign medical graduates (FMGs).

More than one-quarter of the nation's FMGs train in New York City which has been unable to attract enough American medical graduates to fill house staff positions.

Because of the reluctance of American trained physicians to serve in poor and medically underserved neighborhoods, approximately forty-three percent or 1,700 out of 4,000 house officers in HHC facilities are FMGs and the departments of several of our hospitals are totally dependent on FMGs.

HHC is developing a strategy for reducing its reliance on FMGs but the success of this strategy is threatened by existing provisions of the Health Professions Educational Assistance Act of 1976. This act drastically reduces the granting of visas to FMGs seeking entry to the United States. Its effect has been cushioned, so far, by the granting of waivers to hospitals demonstrating that the loss of FMGs would disrupt their services. However, this grace period runs out on December 31, 1980 and the number of entering FMGs will decline steadily from 3,057 to 1,100 by 1984.

HHC's strategy, as described in the accompanying report, requires time for implementation. A sudden interruption of FMG availability would impact severely on HHC hospitals and voluntary hospitals serving similar inner-city populations.

Therefore, we urge the Congress to enact amendments to the Act which will achieve the following results:

- Extend until December 31, 1985 the period during which hospitals may seek waivers from existing entry qualifications for FMGs.
- Allow FMGs entering the county under the new restrictions to stay long enough to complete their training program (usually four to five years). The law now imposes a two-year limit.
- Permit the use of National Health Service Corps doctors in urban municipal hospitals, either as interns or residents or as medical staff.

The following report details the historical and legislative perspective and the principal elements of the Health and Hospitals Corporation strategy to reduce its reliance on foreign medical graduates.

The New York City Health and Hospitals Corporation ("HHC") operates seventeen hospitals and numerous clinics for the City of New York. It also operates the Emergency Medical Service which responds to more than 600,000 calls for ambulance service annually. HHC hospitals have a total bed complement of nearly eleven thousand and provide over three million inpatient days of care and some six million emergency room and clinic visits per year.

HHC facilities serve the poor and near-poor, many of whom would not be treated elsewhere. Most of these facilities are located in medically under-served areas of the City and HHC facilities are often referred to as "family doctors for the poor." Because of their inner-city location and attendant social conditions a number of HHC hospitals have found it difficult to recruit graduates of United States medical schools.

As a result, despite the desire of all HHC hospitals to fill house staff positions with American medical graduates, approximately forty-three percent of all house officers in HHC facilities are foreign medical graduates ("FMGs") and departments of several hospitals are totally dependent on FMGs.

The New York City Health and Hospitals Corporation, believing its FMG dependence, and its problems in seeking alternate sources of medical personnel, to be representative of several areas of New York State and several adjoining states as well, urges

Congress to ameliorate the restrictions on FMGs contained in the Health Professions Educational Assistance Act of 1976, and to assist FMG-dependent hospitals in recruiting physicians from other sources.

LEGISLATIVE HISTORY

The Health Professions Educational Assistance Act of 1976 ("Act") (P.L. 94-484 as amended by P.L. 95-83) significantly altered the provisions of the Immigration and Nationality Act applicable to foreign medical graduates who enter the United States as either permanent immigrants (I Visa holders) or as temporary visitors (J Visa holders). Congress, believing that United States medical schools were producing enough graduates to fill all internships offered in American hospitals, held that the practice of medicine was no longer considered a "shortage occupation." The changes were therefore designed to restrict the entry of FMGs into this country.

Specifically, the law:

1) raised the educational requirements for entry by substituting the Visa Qualifying Examination for the ECFMG examination. (The present VQE pass rate of twenty-five percent and the long lead time required for application have greatly diminished the pool of qualified FMGs);

2) imposed a limit of two years of training in the United States on alien physicians. This period is shorter than virtually all approved residencies thereby greatly diminishing the attractiveness of American graduate medical education to FMGs. Prior to this change, FMGs could remain in the country for the duration of their training period;

3) prevented FMGs from obtaining I Visas based on educational preference; accordingly, FMGs must enter this country either on a J Visa, which is not convertible to an I Visa, or follow normal immigration procedures based on quotas for individual countries. The ability of foreign medical graduates to immigrate was thereby greatly curtailed;

4) permitted specific programs within hospitals to seek waivers from the testing requirement imposed in paragraph one above, provided that the number of FMGs in the program was gradually reduced. The allowed time for obtaining such waivers expires on the last day of 1980.

The restrictions imposed by the 1976 Act have already had a substantial impact on the flow of FMGs into the United States. The Department of Health, Education and Welfare estimated in

1979 that approximately 2,500 alien physicians enter the country under the new provisions of the Act, compared to previous totals of 7,500 physicians per year.

HEALTH & HOSPITALS CORPORATION'S RELIANCE ON FOREIGN MEDICAL GRADUATES

In academic year 1977-78 the Health and Hospitals Corporation and its affiliated voluntary institutions employed 3,992 house officers; FMGs represented 43 percent of that work force (1,701 of 3,992 individuals).

A follow-up survey conducted in November 1979 revealed that both the percentage and distribution of foreign medical graduates were essentially unchanged, notwithstanding the advent of the Act.

Foreign medical graduates are unequally distributed through the municipal system on an institutional basis (Table 1).

The percentage of FMGs in each institution is related to both the strength of the affiliation institution and the physical condition and location of the hospital. Direct medical school or major voluntary affiliates have the most success in recruiting USMGs. Weak voluntary affiliates have the least success.

FMGs are also unequally distributed through the various hospital departments (Table 2). For example, Anesthesiology and Pathology have very high percentages of FMGs in their training programs; however, the majority of alien physicians are in the primary care areas (Medicine, Pediatrics, OBS/GYN and Surgery) which provide direct patient care. Any discontinuance in the availability of these primary care physicians without adequate replacement will create a substantial health care emergency in New York City. The table below shows the number and percentage of alien physicians in these major service areas in HHC hospitals:

Department	% FMGs	Number of FMGs
Pediatrics	62	322
Surgery	49	287
Medicine	25	246
OBS/GYN	41	112

These four departments account for over 50% of the alien physicians and are responsible for the majority of direct care delivered in HHC institutions.

Health and Hospitals Corporation hospitals have already experienced a sharp decrease in the number of applications received from FMGs for house staff training positions for the 1980-81 academic year. A questionnaire survey of HHC facilities and affiliated institutions revealed that the number of applications received by December 15, 1978 was eight percent less than had been received by the same date previously. The drop in applications was not uniform but rather was concentrated at the institutions most dependent on aliens for the provision of medical care. A follow-up survey is currently in progress which indicates that the decline in applications for this academic year is even more pronounced than in the previous year. Heads of the involved clinical departments have attributed this decline to a number of factors including:

1) confusion about the provisions of the revised immigration laws,

2) the time limitation of three years of training in the United States for FMGs.

Since a reduction in the number of FMGs applying for house staff positions has not in and of itself increased the desire of graduates of U. S. medical schools (USMGs) to apply for programs in HHC institutions, it has been necessary to obtain waivers and, where possible, to hire any available personnel with appropriate medical credentials who are willing to work in a municipal hospital setting. The number of such persons is limited and this hiring resource may already have been exhausted.

Finally, it should be noted that FMG dependence has not been confined to municipal hospitals in New York City. Many voluntary hospitals, particularly those which serve similar populations as municipal facilities have serious recruitment problems which have been aggravated by passage of the Act; requests for waivers by voluntary hospitals confirm this assertion.

Serious FMG dependence is not limited to New York City and or indeed to New York State. The study undertaken by the AMA in 1977 shows substantial state-wide FMG dependence in a number of states (Table 3). It is safe to assume that if the distribution of FMGs was wide-spread in 1977, it probably remains so today.

COMMITMENTS TO CHANGES IN RECRUITING PROGRAMS

The New York City Health and Hospitals Corporation fully supports the apparent goal of existing Federal legislation governing entry of FMGs--i.e., filling all physician training positions in American hospitals with United States medical graduates

The intent of the legislative changes offered at the beginning of this paper is not to alter this goal, but to allow hospitals which rely heavily on FMGs to devise alternative recruiting strategies. Commencing such strategies properly and, more important, determining if they will generate enough doctors requires time. It is urged here that until it has been proven that USMGs are available and willing to serve in all hospitals, the use of legally qualified FMGs should be extended.

In whatever time is allowed for the temporary continued use of FMGs, the Health and Hospitals Corporation is determined to take the following steps:

1) increase recruitment of United States medical graduates;
2) increase recruitment of qualified United States

foreign medical graduates ("USFMGs");

3) recruit VQE qualified foreign medical graduates;

4) provide care with attending physicians and/or physician extenders ("PEs");

5) review programs to determine the feasibility of adjusting such programs to diminished staffing capacity.

1) Increased Recruitment of United States Medical Graduates

In 1978, 14,395 students graduated from medical schools in the United States; eight percent of these graduates attended medical school in New York City. Retention of a greater number of these graduates is crucial if reliance on FMGs is to be decreased.

The majority of USMGs who enter the municipal system are attracted to the major teaching hospitals that are closely allied with a medical school or a prestigious voluntary teaching hospital. The results of the National Interns and Residents Matching Program ("Match") vary from one HHC institution to another. A 1979 survey conducted by HHC showed that certain hospitals offer and fill 100 percent of their openings through the Match; others request matches for only some positions and receive none. Over all, 42 percent of all HHC entry level positions were filled by the Match, and 65 percent of all positions offered by HHC in the Match were filled. This survey also demonstrated that municipal hospitals with strong affiliates can recruit through the Match, but very few USMGs choose to train at the smaller, less well-known Corporation hospitals. Therefore, training must be made more attractive through a variety of different means. Specific actions planned include:

A) Since strong affiliations have proven to be an effective means of attracting USMGs, efforts will be made to strengthen affiliations where possible. For example, the Corporation is committed to closing two of its older institutions, Cumberland and Greenpoint Hospitals, and replacing them with the new Woodhull Hospital. Woodhull will be a direct teaching hospital of Downstate Medical School which is a division of the State University of New York (SUNY). This should have a positive effect on recruitment since the strong SUNY affiliation and ultra-modern facility will be positive recruitment factors when compared with the previous weaker voluntary affiliates and ancient physical plants at the hospitals to be closed.

B) The Health and Hospitals Corporation will continue efforts to totally integrate all currently free-standing training programs operated in its facilities with those operated by affiliates. This strategy is specifically applicable to subspecialty training programs. In primary care programs such as medicine and pediatrics, the need for continuity of care may dictate against routine rotation of all house staff through several institutions. Integration of training programs with those of strong affiliates has a number of benefits. The recruitment efforts are strengthened, the programs benefit from the expertise provided by the expanded number of attending physicians and the number of individuals required in a single combined program is often less than in a number of free-standing programs.

C) The Corporation will request that the State University of New York and the New York State Legislature require medical students at state supported institutions to enter into a payback agreement for a portion of the state subsidy that they have received towards their education. The Corporation proposes that students entering school be required to agree to pay back a portion of the subsidy or practice or train in medically underserved areas of New York State for three years.

Since many physicians make their career choices about practice location during training, this is an opportunity to encourage many young physicians to remain in the municipal system.

D) HHC will request that the State of New York assign a number of the medical students who will graduate from both the University of Vermont and the Sackler School of Medicine in Israel under New York State scholarship sponsorship to the municipal system. These individuals owe the State of New York a number of years of service in underserved areas in exchange for their education. The Corporation will request 25 of these individuals in the next academic year.

E) Recruitment of National Health Service Corps physicians into the municipal system. This policy would require changes in the Federal Law governing Corps members since they are currently barred from counting periods of training as fulfillment of their service obligation. A change in these rules would enable American-trained physicians to work in designated hospitals located in Health Manpower Shortage Areas and fulfill their obligation to the Federal government. The programs would be primary care type residencies that Corps members could choose in lieu of other assignments.

2) Recruitment of United States Foreign Medical Graduates (USFMGs)

The American Association of Medical Colleges estimates that approximately 6,000 Americans are currently attending medical school outside of this country. The majority of USFMGs are natives of the Northeastern portion of the U.S.; over 40 percent enter training programs in New York State. In 1978, 6.4 percent of the house officers in programs affiliated with the New York City Health and Hospitals Corporation were USFMGs (251 of 3,992).

The Health and Hospitals Corporation will actively seek to hire a greater number of qualified USFMGs to replace alien physicians. A variety of means will be employed to attract qualified students including:

A) Expansion of elective offerings and externships for qualified USFMGs. Students participating in these programs receive exposure to the municipal institutions and often apply for post-graduate positions in these hospitals. The cost of such efforts are small and afford the opportunity to recruit and evaluate students.

B) A request by HHC to the State University of New York to waive the $4,500 tuition for Fifth Pathway students in exchange for a pledge to accept house officer training in designated areas. A recent report in the New England Journal of Medicine indicated that the majority of both New York State residents and non-residents in New York Fifth Pathway programs remained in the State for training after completion of those programs. Expansion of the Fifth Pathway combined with tuition forgiveness plans could provide additional physicians for shortage areas. A number of voluntary institutions are currently waiving the tuition in exchange for a promise to train in the institution once the training year is completed. Since many of the Fifth Pathway programs are affiliated with SUNY Downstate, the State of New York's approval is necessary for this to be effective in the municipal system.

3) Recruitment of VQE Qualified Foreign Medical Graduates

Recruitment of foreign medical graduates is possible under the provisions of P.L. 94-484; the potential number of alien physicians who will be available in the future is subject to much debate. The Department of Health, Education and Welfare estimates that approximately 2,500 FMGs will enter the U. S. annually after expiration of the waiver provision, while a study conducted by the New England Journal of Medicine projects reduction of from 33 to 60 percent from the 1975 total of 8,000 entrants.

The New York City Health and Hospitals Corporation has accepted the HEW projection of 2,500 entrants for its planning purposes. It is estimated that approximately one hundred fifty entry level FMGs will be recruited from the available pool representing six percent of the total, a reduction of 64 percent from the 400 FMGs in HHC entry level positions currently. However, this estimate may be exaggerated since most FMGs in the municipal system have entered on I Visas and many have used the family preference procedures in the past. FMGs who enter would be highly qualified and available for both education and training. VQE qualified applicants would be directed to the primary care specialties where their services are most acutely needed rather than the more esoteric clinical subspecialties.

4) Use of Attending Physicians and/or Physician Extenders

The complete replacement of FMGs with either attending physicians and/or physician extenders is neither financially feasible nor practical, but HHC is prepared to use such personnel when and if FMGs in vital primary care programs cannot be replaced from other sources.

Economically, replacement of even small numbers of house officers is extremely expensive. The reasons are as follows:

A) House officers generally work between 65 and 80 hours per week. Three or four salaried professionals would be required to replace two house officers.

B) Replacement personnel (either MDs or PEs) are less willing to work many of the night and weekend hours required.

C) House officers are paid approximately the same salary as physician extenders and less than one-half what an attending physician receives. The compensation formula of house staff does not allow for overtime; other employees are entitled to this benefit.

D) Physician extenders are not physicians and therefore are inappropriate for many of the duties of house officers;e.g., coverage of I.C.U.s at night. By law, physician extenders must be supervised by an attending physician when they work.

Because of the above factors, the average incremental cost of replacing a house officer with salaried staff is approximately $34,000. Therefore, replacement of only 30 FMGs with either attendings or physician extenders would cost one million dollars. There are 1,700 FMGs in the system currently.

Replacement has taken place in a number of significant areas. For example, the Department of Pediatrics at Kings County Hospital currently employs five physician extenders and is looking for additional individuals. The Department of Pathology at Downstate Medical Center has begun an innovative Pathology assistant program to enable them to lessen both their own dependence on aliens and provide individuals for other hospitals. The Corporation is also heavily utilizing nurse anesthetists to replace Anesthesia residents where possible. Numerous efforts are underway -- the major hindrance is the cost. However, where necessary, both physician extenders and attending physicians will be hired to replace FMGs to prevent service interruptions.

5) Reduction of Training Programs

The Corporation is committed to assessing its need for existing training programs and to reduce or phase them out if they prove to be either unnecessary or impossible to maintain because of the changed immigration laws. The Corporation has already examined a number of programs in the past and made reductions in positions. For example, in 1978 a number of Pathology programs agreed to a voluntary reduction in size over a four year period. The net result will be a reduction of 20 positions representing 18% of all available training program positions in Pathology. In addition, the Surgery program in one HHC hospital was reduced by fifteen positions in 1979 to more accurately reflect the workload at that institution.

Efforts to reduce programs will focus on ancillary departments and more specialized areas, since the service demands of virtually all primary care programs make cutbacks undesirable.

CONCLUSIONS

While the New York City Health and Hospitals Corporation is committed to reforming its policies and recruiting and hiring physicians or other appropriate personnel to carry out the duties now performed by FMGs, time is sought to implement these policies before all recourse to FMGs is legally barred.

Other hospitals in New York and other states rely so heavily on FMGs that abrupt termination of their services, as presently called for by the Health Professions Educational Assistance Act, would cause a severe disruption of services in such hospitals.

HHC urges the approval of amendments to the Act which would:

1. Extend the existing period in which waivers from the Act may be sought;
2. Extend the length of time an FMG may remain in this country to complete his medical training before returning to his country of origin;
3. Permit the use of National Health Service Corps physicians in urban hospitals, either as interns or residents or as medical staff.

These amendments would allow all hospitals now reliant on FMGs to gradually abate that reliance and come into compliance with Federal policy on health manpower in hospitals.

TABLE 1

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

HOSPITALS RANKED BY PERCENTAGE OF FOREIGN MEDICAL GRADUATES

HOSPITAL	PERCENTAGE OF FMGs	NUMBER OF FMGs
CUMBERLAND	89	91
GOLDWATER	87	7
GREENPOINT	87	45
LINCOLN	82	133
CONEY ISLAND	69	79
HARLEM	55	147
ELMHURST	51	112
KINGS COUNTY	42	200
METROPOLITAN	36	89
QUEENS GENERAL	27	29
BELLEVUE	23	87
BRONX MUNICIPAL	22	72
NORTH CENTRAL BRONX	18	16

1978 Survey
New York City Health and Hospitals Corporation

TABLE 2

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION AND AFFILIATES

SPECIALTIES RANKED BY PERCENTAGE OF FOREIGN MEDICAL GRADUATES

DEPARTMENT	PERCENTAGE OF FMGs	NUMBER OF FMGs
ANESTHESIA	91.6	184
RADIOTHERAPY	87.5	7
REHABILITATION MEDICINE	86.9	73
THORACIC SURGERY	77.8	14
PATHOLOGY	75.4	126
NUCLEAR MEDICINE	66.7	2
PEDIATRICS	61.3	322
SURGERY	49.2	287
OBS/GYN	41.6	112
NEUROSURGERY	41.2	14
PSYCHIATRY	41.0	134
PLASTIC SURGERY	40.9	9
NEUROLOGY	38.1	32
UROLOGY	36.2	29
ENT	33.3	11
DIAGNOSTIC RADIOLOGY	30.1	53
ORTHOPEDICS	24.7	24
INTERNAL MEDICINE	24.6	246
DERMATOLOGY	14.6	7
FAMILY PRACTICE	10.0	5
OPHTHAMOLOGY	9.0	9

Housestaff Survey 1978
New York City Health and Hospitals Corporation

TABLE 3

RELIANCE ON FMGs BY STATE (1977)*

	PERCENT FMG OF TOTAL	PERCENT OF HOSPITALS OVER 50% FMG
CONNECTICUT	73.2	21.7
NEW JERSEY	58.2	51.1
NEW YORK	41.8	49.1
ILLINOIS	41.5	48.6
DELAWARE	40.6	33.3
MARYLAND	39.1	50.0
MICHIGAN	29.4	41.5
OHIO	28.5	36.0

While all specialties have a substantial number of FMGs, the most dependent specialties in percentage terms tend to be pathology, anesthesiology, rehabilitation medicine, psychiatry, and therapeutic radiology, but in both absolute numbers and percentages, general surgery, pediatrics, internal medicine, and obstetrics-gynecology are also critically reliant upon FMGs. The major voluntary medical centers are less dependent upon FMGs in percentage terms than state, local and other unaffiliated hospitals, but the greater numbers of FMG house staff are found in major hospitals affiliated with medical schools. One type of hospital, however, especially depends on FMGs, namely, the State mental hospital. Above all, the FMG is a critical manpower source for the major metropolitan areas of the country.

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*Way, Peter O., "Foreign Medical Graduates in U. S. Graduate Medical Education Programs, 1977," Socioeconomic Issues of Health, 1978, Center for Health Services Research and Development, American Medical Association, Chicago, Illinois, 1978, pp 77-78 as quoted in the New York State Health Planning Commission, May, 1979 report on FMGs in New York City.

Mr. **Waxman**. Our first witness is Mr. Joseph Blundon, Assistant General Counsel of the International Communication Agency.

Mr. Blundon, we are pleased to have you with us.

STATEMENT OF JOSEPH A. BLUNDON, ASSISTANT GENERAL COUNSEL, INTERNATIONAL COMMUNICATION AGENCY

Mr. **Blundon**. Thank you, Mr. Chairman.

Mr. **Waxman**. I believe we have your prepared statement and we will make that part of the record in its entirety, but I would like to ask you, if you would, to summarize your testimony.

Mr. **Blundon**. I will.

Mr. Chairman, I am most grateful for the opportunity to be here on a matter which I think is most important——

Mr. **Waxman**. Excuse me. Let me interrupt you for a moment. I understand that you were planning to use a little bit more time. Before you even get started, there is a vote on the House floor and rather than have you get started and interrupt you I would rather break for a minute or two and vote. Some other members will be joining us, I am sure, after they have the opportunity to vote and then we will start with your testimony.

Mr. **Blundon**. All right.

[Brief recess.]

Mr. **Maguire** [presiding]. The subcommittee will come to order.

Mr. Blundon, you have been introduced, I believe, already to the committee.

Mr. **Blundon**. Yes, sir.

Mr. **Maguire**. We will be happy now to take your statement.

Mr. **Blundon**. Mr. Chairman, I am grateful for the opportunity to appear here today on a matter that I think is most important from the point of view of the public health, commercial interests and the foreign policy of the United States. I am Assistant General Counsel of the U.S. International Communication Agency, popularly known as ICA and formerly known as the U.S. Information Agency or USIA. We operate the Voice of America and a network of libraries and information centers around the world designed to inform the people of other nations about the United States of America and its people and its policies.

Since April 1, 1978, by virtue of Reorganization Plan No. 2 of 1977, ICA has also had primary responsibility within the executive branch for international educational and cultural exchange visitor programs which formerly had been a function of the Department of State. That includes those programs under which foreign medical graduates receive advanced medical education and training as exchange visitors and then return to their native countries to use the skills acquired here to improve the health and welfare of their fellow citizens.

Immediately after acquiring responsibility for these programs, we realized that Public Law 94-484 which was a 1976 amendment to section 212 of the Immigration and Nationality Act was having a devastating effect on the role of the United States as the recognized leader among nations in providing advanced medical education.

The primary problem we saw was that Public Law 94-484 reduced to a maximum of 3 years the length of time a foreign medical graduate could spend in this country as an exchange visitor pursuing a program of advanced medical education or training. In most cases this involved a residency or a fellowship program designed to qualify such a foreign medical graduate to take the examination required to become a certified medical specialist. Now at the present time only three medical specialty certifying boards—those in internal medicine, general practice and pediatrics—will examine doctors for certification after as little as 3 years of residency. The average training time requirement is 4½ years and the maximum is 12 years. As a result——

Mr. MAGUIRE. Excuse me. What was the limit?

Mr. BLUNDON. Before Public Law 94-484 the limit was 5 years and also provided for extensions in appropriate cases.

As a result of this, since January 10, 1977, we had to tell foreign medical graduates interested in studying in this country at the very beginning that they would not be allowed to stay here long enough to complete their residency programs for specialty certification.

The United States has for many years been the recognized leader in providing advanced medical training to the physicians and surgeons of the world. They have come here, studied, qualified as specialists and gone home to contribute to the development of their native countries and become prominent and influential citizens and in many cases officials in hospitals, universities and governments. They have been good customers for American medical and scientific equipment and pharmaceuticals and they have proved to be a reservoir of public opinion and political influence favorable to this country overseas.

Since the effective date of Public Law 94-484, the number of foreign medical graduates in this country pursuing advanced medical education and training has decreased from 5,090 on January 10, 1977, to 2,578 on January 10, 1979, and it is about 2,000 at the present time and the number is continuing to go down.

ICA as one of the foreign affairs agencies has received numerous expressions of anxiety and distress from other nations, particularly Venezuela, Mexico, Saudi Arabia, Ecuador, Panama, Iceland, Egypt and Cyprus all of which have in the past relied primarily on the United States for advanced medical training. It is rare that a week goes by in my office that we don't get a call from an Embassy of some foreign country expressing continuing concern about this situation.

We have also learned that the Soviet bloc is taking advantage of this situation by sharply increasing recruiting efforts among doctors, particularly in the developing countries, offering liberal scholarships and fellowships for full-term graduate medical education. For example, in 1978 from Panama alone more than 100 persons who in the past would have normally come to the United States have gone to Communist countries to pursue their medical studies. We feel that this trend will continue unless and until the Congress acts to amend section 212(J) of the Immigration and Nationality Act along the lines set forth in title VI of H.R. 6802.

The first foreign medical graduates who came to the United States as exchange visitors after January 10, 1978, will be reaching their mandatory return dates around July of this year. Any who are required to leave then will not be eligible to reapply for admission until they have spent at least 2 years in their home countries and the flow of new medical exchange visitors from other countries will continue to decrease.

The only result of this can be a retreat from the position this country has enjoyed in worldwide medical education, a diminution in American assistance to developing nations and the American contribution to the health of the peoples of the world and a decrease in the world market for American produced pharmaceuticals and medical and scientific equipment. We feel that the need for this legislation is immediate and urgent.

In addition to its impact on the commercial interests, prestige and the foreign policy of the United States, Public Law 94-484 has had a crippling effect on American hospitals, particularly those in major metropolitan areas, by cutting off a major source of the resident physicians and surgeons who in the course of pursuing their specialty training and under supervision by fully certified specialists provide much of the day-to-day medical care provided to the public. The foreign medical graduates who were already here when the new law took effect are gradually being required to return home pursuant to section 212(e) of the Immigration and Nationality Act and very few new ones are coming in because except for internists, pediatricians, and general practitioners they cannot stay long enough to complete a certification program.

ICA drafted and sent to the Congress, after clearance by OMB, a bill which would, like title VI of H.R. 6802, alleviate this situation. Your subcommittee staff has our draft bill and an amendment to it which was suggested by the Association of American Medical Colleges with which we fully agree.

The difference between the two bills is primarily that our draft was basically open ended which would permit determining case by case how long a medical exchange visitor could stay based on the official requirements of the medical specialty certifying board for the program he or she is pursuing rather than having a 7 year maximum as in H.R. 6802.

The determination of length of stay under either bill would be made by the Director of ICA in each case on the basis of criteria developed by the Director in coordination with the Secretary of Health and Human Services. Under either bill all foreign medical graduates would continue to be tested for English language fluency and medical competence by means of the Visa Qualifying Examination as they are now. They would continue to be screened for eligibility and be sponsored by exchange visitors by the Educational Commission for Foreign Medical Graduates under contract with ICA.

Either bill would permit a foreign medical graduate with the approval of the Director to change his or her program of study no more than once and no later than the end of the first 2 years following entry into the United States. Both bills would apply to all foreign medical graduates entering the United States as exchange visitors to pursue programs of graduate medical education or training on or after January 10, 1978, which was the effective date of the 3-year limitation.

Although I have limited my discussion almost entirely to paragraph 3 of subsection (b) of section 601, might I also state that the International Communication Agency concurs in and urges the enactment of the remainder of section 601 as well.

Again, I would like to thank the subcommittee for the opportunity of testifying today and I would be most happy to answer any questions of the chairman or any member of the subcommittee might have.

Mr. **Waxman**. Thank you very much. We are pleased to have your testimony on this aspect of the legislation.

For the record, what is the relationship between ICA to the Department of State?

Mr. **Blundon**. ICA and its predecessor USIA became an independent agency in 1953. We, of course, had a close working relationship with the Department of State and under the reorganization plan that created ICA our Director reports directly to the President and to the Secretary of State. We receive foreign policy guidance from the Secretary of State but otherwise operate completely as an independent agency.

Mr. **Waxman**. If we extended the time available for graduate medical training for FMG's as you propose, what prediction does the agency make in regard to the number of FMGs today and those in such training in 5 years?

Mr. **Blundon**. That would be difficult to estimate but my best guess would be that it would go up to at least the numbers that we had at the time Public Law 94-484 took effect which was something over 5,000. There certainly is a continuing need for those foreign medical graduates in our hospitals. We had hoped at the time Public Law 94-484 was enacted that the American medical colleges would be able to supply that need but it just has not worked out that way.

One thing I might say is that part of my duty as Assistant General Counsel of ICA is to make decisions on whether or not foreign medical graduates and other exchange visitors for that matter, who have completed their programs will be granted waivers of the 2-year foreign residency requirement which are provided for under the Immigration Act. The Agency plans to be very strict in that regard and to vigorously enforce the requirement that exchange visitors, including foreign medical graduates, return home after completing their programs. So we hope that the brain drain which was a problem before will not be a problem again.

Mr. **Waxman**. What negative effects can we expect if we are unable to complete this bill by July 1?

Mr. **Blundon**. We will begin to have to send some foreign medical graduates back to their home countries under the requirements of section 212(e) of the Immigration and Nationality Act because they will have completed their programs and the law would prohibit their staying here further.

Mr. **Waxman**. Do you have any estimate of numbers of people involved?

Mr. **Blundon**. I think probably Dr. Casterline can give a more reliable estimate on that.

Mr. **Waxman**. We are talking about foreign medical graduates who want to complete their studies in the United States?

Mr. **Blundon**. That is it.

Mr. **Waxman**. We are not talking about how to handle foreign medical professionals who want to come to the United States to live permanently?

Mr. **Blundon**. No, it has nothing to do with that.

Mr. **Waxman**. Thank you.

Dr. Carter.

Mr. **Carter**. Thank you, Mr. Chairman.

How would this serve as a brain drain on the United States?

Mr. **Blundon**. I don't think there is any danger of there being a brain drain of the United States. Other nations complain that some of their very best medical personnel were coming here, receiving their graduate medical training and certification but instead of going home to use what they had learned here they were staying in this country.

Mr. **Carter**. Yes, sir, and instead of 2 or 3 years, you would let them stay here 7 years, is that correct?

Mr. **Blundon**. That is what this bill provides.

Mr. **Carter**. Would they not be more likely after 7 years staying here to find a way to stay rather than to go back? Wouldn't the bill actually increase the likelihood of a brain drain from the country from which they came?

Mr. **Blundon**. In no circumstances is an exchange visitor permitted to stay here after completing his or her program unless they can bring themselves within one of the grounds for a waiver provided in the Immigration and Nationality Act. The most common is hardship to an American citizen spouse or child. As I said a moment ago, we plan to be very strict in enforcing that requirement and examining each case very closely to make sure the requirements of that law are fully met. This is actually in each case a joint decision between the International Communication Agency and the Immigration Service.

Mr. **Carter**. That is, you would strongly enforce the 7-year requirement?

Mr. **Blundon**. Well, it would be 7 years or less depending on the individual's program.

Mr. **Carter**. I see. How many U.S. graduates require 7 years for their graduate medical training?

Mr. **Blundon**. Again I would like to defer to Dr. Casterline on that because he knows a great deal more about it than I do. I think there is only one that goes beyond that and that is psychiatry.

Mr. **Carter**. Not psychiatry but——

Mr. **Blundon**. With a subspecialty, yes.

Mr. **Carter**. What would be your reaction to placing a number or percentage limit on this authority to prevent it from becoming a loophole for immigration?

Mr. **Blundon**. Well, I think the problem of preventing it from becoming a loophole for immigration can be best met by strictly enforcing the provisions of section 212 of the Immigration and Nationality Act. As a matter of fact, the visa qualifying examination has proved to be a very highly effective limit on the number who can enter this country because it is a very demanding examination.

Mr. **Carter**. You mean the VQE, I believe.

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Mr. **Blundon**. Yes, for the visa qualifying examination.

Mr. **Carter**. What has happened to the FMG's who were in a U.S. training program in 1976 when the amendments were passed?

Mr. **Blundon**. They have been completing their programs and going home.

Mr. **Carter**. They have been going home? That is over 2 years ago, I believe.

Mr. **Blundon**. Yes.

Mr. **Carter**. They have not all gone home then.

Mr. **Blundon**. I can't be sure as to the numbers. I know from the correspondence that goes through my office all the time that a great many have gone home.

Mr. **Carter**. How many have stayed and become U.S. citizens?

Mr. **Blundon**. Again, I cannot answer that. Only the Immigration Service would have those figures.

Mr. **Carter**. All right. In deciding whether or not to grant the waiver that is permitted under current law, how do you determine whether the services would be substantially disrupted?

Mr. **Blundon**. Now the substantial disruption waiver is a separate problem all together. Substantial disruption waivers are not granted to individuals, they are granted to hospitals and medical colleges and——

Mr. **Carter**. Hospitals in particular, isn't it?

Mr. **Blundon**. Yes. I happen to be a member of the Interagency Substantial Disruption Waiver Review Board that passes on applications from hospitals for substantial disruption waivers. Now the effect of a substantial disruption waiver permits a hospital to bring in a foreign medical graduate who has not yet passed the VQE. He still has to pass it after he gets here but he does not have to pass it as a prerequisite for coming in.

Mr. **Carter**. What incentives are there under the provision in H.R. 6802 which extends this waiver, for hospitals to try to reduce their dependence on foreign physicians?

Mr. **Blundon**. The educational provision in cooperation with the Department of Health and Human Services and our Agency have developed a criteria which really are quite strict and hard to satisfy. Since the Substantial Disruption Waiver Review Board has been established we have turned down considerably more applications than we granted but still the rate of applications for such waivers continues to increase, particularly from hospitals in major metropolitan areas.

Mr. **Carter**. What percentage of physicians in the United States today are FMG's?

Mr. **Blundon**. I don't know that, Mr. Carter. I think Dr. Casterline will be able to supply that information.

Mr. **Carter**. You could provide it for the record?

Mr. **Blundon**. Yes, I can.

Mr. **Carter**. All right.

Thank you very kindly, Mr. Chairman.

Mr. **Waxman**. Mr. Maguire.

Mr. **Maguire**. Mr. Chairman, this waiver provision, I am not sure I fully understand the history and I wonder if we can ask the witness. Do you know what the history of this J-1 waiver is? Is that a tough new policy that has been implemented just in the last couple of years since Public Law 94-484 was passed or another? What were we doing before that? I am trying to figure out whether we have some reasonable expectation that things are going to be different in the future if we become more flexible than we were previously.

Mr. **Blundon**. Well, the possibility of granting waivers from the 2-year foreign residence requirement has long been part of the Immigration and Nationality Act. Basically for foreign medical graduates the only ground for waiver is hardship to an American citizen, spouse, or child.

Mr. **Maguire**. That is the present situation.

Mr. **Blundon**. Right.

Mr. **Maguire**. What was the situation 5 years ago?

Mr. **Blundon**. That same provision was in the law 5 years ago.

Mr. **Maguire**. Did we not have some concern at that time that too many foreign medical graduates were in fact staying in our country beyond their graduate work? And was that not the concern?

Mr. **Blundon**. That is right.

Mr. **Maguire**. Then my question is what is going to be different between that earlier period when we had that concern which resulted partly in the passage of this legislation that we are talking about—what is going to be the difference between that earlier time and what will be the case after we pass this legislation if the immigration laws are still the same?

Mr. **Blundon**. Well, one of the things that Public Law 94-484 did was remove the possibility of granting a waiver of a 2-year foreign residence requirement to a foreign medical graduate simply on the basis of a letter from his or her home government saying it is all right if this person stays. We can do that for other exchange visitors now but no longer for doctors. And that would continue to be the case under H.R. 6802.

Mr. **Maguire**. So that is the new element then, it means that we are in control of evaluating hardship?

Mr. **Blundon**. That is right.

Mr. **Maguire**. Not someone else which we then rubber stamp.

Mr. **Blundon**. In order to grant a hardship waiver the decision is made in the first instance by the Immigration Service and in any case where the Immigration Service finds hardship then they come to the International Communication Agency for a recommendation. If ICA says, yes, we agree that there is hardship, then the waiver is granted. If ICA says no, then the waiver is not granted. ICA has an absolute veto power.

Mr. **Maguire**. Which was not true 5 years ago when you simply accepted a letter from a foreign government.

Mr. **Blundon**. That is correct.

Mr. **Maguire**. Thank you, Mr. Chairman.

Mr. **Carter**. Mr. Chairman.

Mr. **Waxman**. Yes, Dr. Carter.

Mr. **Carter**. Earlier I asked you about the number, foreign medical graduates in this country. I have found the following statistics which I wanted to share with the subcommittee: In 1976 when there were 496,000 Federal and non-Federal positions, foreign Federal graduates made up 84,623 or 21 percent of the total. Also, 36 percent of the 17,724 initial licenses issued by State boards of medical examiners in 1976 were obtained by a foreign graduate. In 1970 slightly more than 27 percent of the initial licenses were issued to FMG's. I believe that answers our question.

Mr. **Blundon**. Yes.

Mr. **Carter**. Thank you.

Mr. **Waxman**. We appreciate your being with us.

Mr. **Blundon**. Thank you, Mr. Chairman.

Mr. **Waxman**. For our next witnesses we call Dr. Ray L. Casterline, executive director Educational Commission for Foreign Medical Graduates accompanied by Miss Maureen Selfron, managing director.

STATEMENT OF RAY L. CASTERLINE, M.D., EXECUTIVE DIRECTOR, EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES, ACCOMPANIED BY MAUREEN SELFRON, MANAGING DIRECTOR

Dr. **Casterline**. Thank you, Mr. Chairman, and members of the subcommittee.

Mr. **Maguire**. Excuse me. Before Dr. Casterline begins I wonder if we could ask him what are the seven leading organizations that sponsor his group just so we know who he represents.

Dr. **Casterline**. The American Medical Association, the American Hospital Association, the Association of American Medical Colleges, the Association for Hospital Medical Education, the Federation of State and Federal Boards, the American Board of Medical Specialties, and the National Medical Association.

Mr. **Maguire**. Thank you very much.

Mr. **Waxman**. Please proceed.

Dr. **Casterline**. I prepared a statement which I have distributed to you. I will speak from that statement. [See p. 540.]

Mr. **Waxman**. The statement in its entirety will be made part of the record.

Dr. **Casterline**. Thank you.

Mr. Chairman and members of the subcommittee, I appreciate the opportunity to appear before you to discuss certain provisions of the Health Professions Educational Assistance and Nurse Training Amendments of 1980. This statement will address the substantial disruption waiver provisions of Public Law 94-484 and the extension of those provisions proposed in H.R. 6802. The proposed increase in the duration of stay of Exchange Visitor Foreign Medical Graduates, EVFMG's, in accredited programs of graduate medical education or training; the proposal to permit EVFMG's to make one change in their training objective and the proposed deletion of "specialty certification" as one of the requirements for alien physicians to meet, if they were in the United States, licensed to practice medicine, and in practice in a State on January 9, 1977, and wished to be considered to have passed the National Board of Medical Examiners part I and part II examinations or to be exempt from the visa qualifying examination which is considered equivalent.

During the past two decades, ECFMG has become most widely known for its examination and certification program. ECFMG certification is a requirement to enter accredited graduate medical education training programs in the United States and facilitates obtaining a license to practice medicine in most of the States in the United States. In addition, ECFMG administers the visa qualifying examination, VQE. Passing the ECFMG English test is not only a prerequisite for ECFMG certification but also to take the VQE.

Pertinent to this discussion, however, is ECFMG's role as a sponsor of an exchange visitor program for alien physicians who enter the United States to participate in accredited programs of graduate medical education or training. The International Communication Agency provides ECFMG authority to serve as a sponsor and to issue the documentation required as one of the prerequisites for an alien physician to obtain a J-1, exchange visitor, visa to enter the United States.

At least three provisions of H.R. 6802 relate to the graduate medical education of alien physicians who have entered, or will enter the United States as exchange visitors under the sponsorship of ECFMG. Each of those provisions will be discussed separately.

Amendments to the Immigration and Nationality Act, contained in Public Laws 94-484 and 95-83, require the application of stringent requirements for issuing exchange visitor, J-1, Visas to alien physicians who seek to enter the United States to participate in accredited programs of graduate medical education or training. The stated intent of these amendments was to decrease reliance on alien physicians and to assure quality medical care for individuals served by these physicians during their participation in graduate medical education training programs in the United States.

The intent has come to fruition insofar as there has been a decrease in numbers of exchange visitor foreign medical graduates. On January 10, 1977, ECFMG sponsored 5,090 exchange visitors. To date ECFMG is currently sponsoring 2,000 exchange visitors. As you can see, this represents a substantial reduction on numbers of exchange visitors.

Since the Congress anticipated this severe reduction they provided for waiver of two of the requirements on a case-by-case basis, if a graduate medical education program could demonstrate that application of these requirements would result in a "substantial disruption" of health services.

The substantial disruption waiver was designed to permit programs and institutions traditionally placing significant reliance on alien physicians a transition period during which placement of such physicians may continue, but in decreasing numbers. During this transition period, extending through December 31, 1980, programs and institutions are expected to develop alternative provider resources and attract primarily graduates of American medical schools.

To put the waiver mechanism into effect, the Department of Health, Education, and Welfare developed: 1, eligibility criteria to identify programs and institutions affected by these provisions and 2, decreasing numerical limits to permit programs and institutions a gradual rate of phaseout for dependency on alien physicians while developing alternative provider resources.

Importantly, an individual who obtains a J-1 visa under a waiver may remain in this country without further waiver review for 2 years, and for 1 additional year if the third year is requested by the home country government. However, an individual must apply to ECFMG each year for continuation of exchange visitor sponsorship.

Since waivers are assigned to programs and/or institutions, individual EVFMG's cannot transfer from waived positions to nonwaived positions without meeting the new requirements of the law and do so at the risk of loss of their J-1 visa status. Also, an alien physician entering under a substantial disruption waiver must hold ECFMG certification.

During a 7-month period in 1978, 20 programs requested a total of 35 waived positions. Nineteen of the waived positions were approved. The programs represented 19 specialties and 14 States. This information is attached for your further reference. [See p. 550.]

During 1979, 34 programs requested a total of 140 waived positions; 108 were approved both in tier 1 which ECFMG is authorized to grant and in Tier 2. The programs in 1979 represented 12 specialties and 12 States. [See p. 551.]

During the first 3 months of 1980, 16 programs requested a total of 186 waived positions; 172 of these have been approved. Although the programs represent 10 specialties in 7 States, 157 of the positions were requested by New York hospitals. [See p. 553.]

Congress provided that in no case will substantial disruption waivers result in a number to exceed the total number of alien physicians participating in programs of graduate medical education or training in the United States on January 10, 1978.

ECFMG monitors the exchange visitor program via a computerized record system. This system permits verification of program start dates and duration of stay for each exchange visitor being sponsored. The system also provides yearly reports which in addition to providing specific information on exchange visitors also provides total counts.

Despite a substantial increase in waiver requests in 1980, the exchange visitor count is 43 percent less than the January 10, 1978, index of 3,531.

From the ECFMG perspective, extension of the waiver through December 1983 would not increase the exchange visitor numbers to the point of running contrary to the intent of the law, nor would it result in exceeding the January 10, 1978, "cap" imposed by the Congress. Extending the waiver provision would, however, give areas such as New York a more realistic period of time to develop and carry out plans to phase down reliance on alien physicians.

Increased duration of stay. ECFMG is aware of the concern regarding the 3-year maximum limitation of stay for exchange visitor alien physicians. This has been expressed by government officials as well as leaders in the medical profession of varioius foreign countries.

This restrictive provision of the law has disrupted many traditional programs of international exchange in graduate medical education between medical schools in Latin America and institutions in the Southeastern United States. There has been a comparable interference with similar programs between institutions in the United States and those in the United Kingdom, Italy, Egypt, Saudi Arabia, and others. It is of interest that schools in countries which provide medical education comparable to that offered in the

United States are most concerned about the restricted length of stay.

From my meetings with various officials and medical leaders in this country and abroad, I feel there is a consensus that the problems posed by the limited duration of stay are primarily educational and relate to the inability to trainees interested in high quality graduate medical education to remain for a sufficient period of time to obtain the education they require. In other words, to obtain a valid education of experience.

One point which was emphasized by physicians from Venezuela, was the hazards the expect, if young Latin American physicians are forced as a result of these restrictive provisions, to receive training in the Soviet Union and other countries where Marxist attitudes prevail.

Once again, from the ECFMG perspective, increasing the duration of stay to allow completion of a training objective would not jeopardize the intent of the law nor would it result in the classic brain-drain syndrome.

One of the recent amendments to Public Law 94-484 requires that exchange visitor alien physicians must make a commitment to return to their home country upon completion of training in the United States. This requirement, in addition to the controls ECFMG has over the issuance of the form 1AP-66, which allows exchange visitors to obtain a J-1 visa, would preclude the exchange visitor from remaining in this country indefinitely. In addition, increasing the duration of stay would, first, probably do much to enhance our international relations with many countries who value the training that the United States has to offer, and second, would also benefit hospitals which are currently depending upon the substantial disruption waiver provision of the law to carry them through the transition period.

Permission to change the graduate training objective is the third point. An alien physician who enters the United States as an exchange Visitor to participate in an accredited graduate medical education training program is required to provide a letter from his home country government stipulating that there is a need in that country for physicians with the type of training that the alien is seeking. Furthermore, the home country government must also certify that the alien has filed a written assurance with the government of his country that he will return upon completion of training in the United States and intends to enter the practice of medicine in the specialty for which the training is being sought that training program is the training objection.

Although most alien physicians who enter the United States as exchange visitor foreign medical graduates adhere to their initial training objective, complete it and return home, some trainees and some countries learn that the initial objective is not appropriate. This can occur for a wide variety of reasons. Under the memorandum of understanding between the International Communication Agency and ECFMG the alien trainee is permitted to make one change in his training objective, but only with the agreement of his home country government, as described above.

The present 3-year maximum stay for exchange visitors, as specified in the provisions of Public Law 94-484, discourages alien physicians from making changes in their training objectives, since a 3-year stay does not provide enough time for a valid educational experience. If the duration of stay for exchange visitors is increased, alien physician EVFMG's should be limited to only one change of objective and that should take place no later than the end of the second year of participation in the exchange visitor program, and only with the agreement of the aliens' home country governments. With such caveats, alien physicians 'changes in their training objectives should not contribute to abuse of the exchange visitor program.

Finally, under specialty certification, ECFMG is not directly involved in the process of licensure to practice medicine in this country. Nonetheless, as a licensed physician, holding a valid certificate issued by a constituent board of the American Board of Medical Specialties, I believe it is important to delete "specialty certification" from the provisions of Public Law 95-83 amendment to the Immigration and Nationality Act. Specialty certification has little to do with licensure practice of medicine in the United States.

Mr. Chairman, this concludes my prepared statement. I will be pleased to answer questions of the chairman and members of the committee.

[Testimony resumes on p. 580.]

[Dr. Casterline's prepared statement and attachments follow:]

EDUCATIONAL COMMISSION for FOREIGN MEDICAL GRADUATES
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Statement of Ray L. Casterline, M.D., Executive Director,
Educational Commission for Foreign Medical Graduates

Mr. Chairman and members of the subcommittee, I appreciate this opportunity to appear before you to discuss certain provisions of the Health Professions Educational Assistance and Nurse Training Amendments of 1980 (H.R. 6802). This statement will address the substantial disruption waiver provisions of the Health Professions Educational Assistance Act of 1976 (Public Law 94-484) and the extension of those provisions proposed in H.R. 6802; the proposed increase in the duration of stay of Exchange Visitor Foreign Medical Graduates (EVFMGs) in accredited programs of graduate medical education or training; the proposal to permit EVFMGs to make one change in their training objective; and the proposed deletion of "specialty certification" as one of the requirements for alien physicians to meet, if they were in the United States, licensed to practice medicine, and in practice in a State on January 9, 1977, and wished to be considered to have passed the National Board of Medical Examiners Part I and Part II examinations.

The Educational Commission for Foreign Medical Graduates (ECFMG) is a separate non-profit organization that is sponsored by seven of the leading organizations in the fields of medical education and health care in the United States.

In recognition and fulfillment of their public responsibilities for health care and education, the sponsoring organizations established ECFMG to concern itself with foreign medical graduates.

To meet its responsibilities, ECFMG identifies the following as its aims and missions:

(l) To provide information to foreign medical graduates regarding entry into graduate medical education and health care systems in the United States:

(2) To evaluate their qualifications for such entry;

(3) To identify foreign medical graduates' cultural and professional needs;

(4) To assist in the establishment of educational policies and programs to meet the above-identified cultural and professional needs of foreign medical graduates.

(5) To gather, maintain, and disseminate data concerning foreign medical graduates; and

(6) To assist, through cooperation and recommendation, other agencies concerned with foreign medical graduates.

During the past two decades, ECFMG has become most widely known for its examination and certification program. ECFMG certification is a requirement to enter accredited graduate medical education training programs in the United States and facilitates obtaining a license to practice medicine in most of the states in the United States. In addition, ECFMG administers the Visa Qualifying Examination (VQE). Passing the ECFMG English test is not only a prerequisite for ECFMG certification but also to take the VQE.

Pertinent to this discussion, however, is ECFMG's role as a sponsor of an Exchange Visitor Program for alien physicians who enter the United States to participate in accredited programs of graduate medical education or training. The International Communication Agency provides ECFMG authority to serve as a sponsor and to issue the documentation (Form IAP-66) required as one of the prerequisites for an alien physician to obtain a J-1 (Exchange Visitor) visa to enter the United States.

At least three provisions of H.R. 6802 relate to the graduate medical education of alien physicians who have entered, or will enter the United States as Exchange Visitors under the sponsorship of ECFMG. Each of those provisions will be discussed separately.

WAIVER PROVISION EXTENSION

Amendments to the Immigration and Nationality Act, contained in Public Laws 94-484 and 95-83, require the application of stringent requirements for issuing Exchange Visitor (J-1) Visas to alien physicians who seek to enter the United States to participate in accredited programs of graduate medical education or training.

In brief, these requirements are

(A) an accredited school of medicine, or any one or more of its affiliated hospitals, must agree in writing to provide or assume responsibility for the graduate medical education or training;

(B) the alien physician must pass the Visa Qualifying Examination (VQE), must demonstrate competency in oral and written English, must be able to adapt to the educational and cultural environment in which he will be receiving his training, and must have adequate prior education for successful participation in the program;

(C) the alien must make a commitment to return to his home country upon completion of training in the United States, and his country must provide written assurance that there is need for the alien's services in his country; and

(D) the alien will be allowed to stay in this country no more than 2 years, unless additional time is specifically requested by his country for a maximum of one additional year. The extension is for the purpose of continuing the alien's education or training under the specific program for which he or she came to the United States.

The stated intent of these amendments was to decrease reliance on alien physicians and to assure quality medical care for individuals served by these physicians during their participation in graduate medical education training programs in the United States.

The intent has come to fruition insofar as there has been a decrease in numbers of exchange visitor foreign medical graduates. On January 10, 1977 ECFMG sponsored 5,090 exchange visitors. To date ECFMG is currently sponsoring 2,000 exchange visitors. As you can see this represents a substantial reduction on numbers of exchange visitors.

Since the Congress anticipated this severe reduction they provided for waiver of two of the requirements on a case-by-case basis, if a graduate medical education program could demonstrate that application of these requirements would result in a "substantial disruption" of health services.

Under the substantial disruption waiver, an Exchange Visitor Foreign Medical Graduate (EVFMG) is not required to:

1. have an accredited school of medicine, or any one or more of its affiliated hospitals provide the graduate medical education; and

2. pass the Visa Qualifying Examination.

The substantial disruption waiver was designed to permit programs and institutions traditionally placing significant reliance on alien physicians a transition period during which placement of such physicians may continue, but in decreasing numbers. During this transition period, extending through December 31, 1980, programs and institutions are expected to develop alternative provider resources and attract primarily graduates of American medical schools.

To put the waiver mechanism into effect, the Department of Health, Education, and Welfare (HEW) developed: 1) eligibility criteria to identify programs and institutions affected by these provisions and 2) decreasing numerical limits to permit programs and institutions a gradual rate of phase out for dependency on alien physicians while developing alternative provider resources.

The design of the waiver mechanism provides for two tiers of waiver application. Tier I is for programs and institutions which meet the eligibility criteria and are requesting waivers within the numerical limitations. Tier II is for programs and institutions which:

1) meet the eligibility criteria but are requesting waivers in excess of the numerical limitations or
2) do not meet the eligibility criteria

ECFMG is the receipt point for Tier I applications, and reviews and processes the applications under the established numerical limits.

Tier II appeal applications are also mailed to ECFMG for initial processing. ECFMG forwards appeal applications to the Health Resources Administration of the Department of Health, Education, and Welfare for consideration. A Federal Substantial Disruption Waiver Appeal Board consisting of seven Federal members has been established to review these applications. The appeal board determines whether programs qualify for additional waivers.

Length of Validity for Waived J-1 Visa Holders

An individual who obtains a J-1 visa under a waiver may remain in this country without further waiver review for two years, and for one additional year, if the third year is requested by the home country government. However, an individual must apply to ECFMG each year for continuation of Exchange Visitor Sponsorship (IAP-66). Also, waived J-1 visa holders must be counted in determining the program's eligibility for future waivers.

Since waivers are assigned to programs and/or institutions, individual EVFMGs cannot transfer from waived positions to non-waived positions without meeting the new requirements of the law and do so at the risk of loss of their J-1 visa (Exchange Visitor) status.

Also, an alien physician entering under a substantial disruption waiver must hold ECFMG certification.

Statistics

During a seven month period in 1978, 20 programs requested a total of 35 waived positions. Nineteen (19) of the waived positions were approved. The programs represented 19 specialties and 14 states.

During 1979, 34 programs requested a total of 140 waived positions. One hundred and eight (108) were approved. The programs represented 12 specialties and 12 states.

During the first three months of 1980, 16 programs requested a total of 186 waived positions; 172 have been approved. Although the programs represent ten specialties and seven states, 157 of the positions were requested by New York hospitals.

Controls

Congress provided that in no case will substantial disruption waivers result in a number to exceed the total number of alien physicans participating in programs of graduate medical education or training in the United States on January 10, 1978.

ECFMG monitors the exchange visitor program via a computerized record system. This system permits verification of program start dates and duration of stay for each exchange visitor being sponsored. The system also provides yearly reports which in addition to providing specific information on exchange visitors also provides total counts.

Despite a substantial increase in waiver requests in 1980, the exchange visitor count is 43% less than the January 10, 1978 index of 3,531.

In conclusion, from ECFMG's perspective, extension of the waiver provision through December 1983 would not increase the Exchange Visitor numbers to the point of running contrary to the intent of the law, nor would it result in exceeding the January 10, 1978 "cap" imposed by the Congress. Extending the waiver provision would, however, give areas such as New York a more realistic period of time to develop and carry out plans to phase down reliance on alien physicians.

INCREASED DURATION OF STAY

ECFMG is aware of concern regarding the three-year maximum limitation of stay for Exchange Visitor alien physicians. The concern has been expressed by government officials as well as by leaders in the medical profession of various foreign countries.

This restrictive provision~~, according to sources of the law,~~ has disrupted many traditional programs of international exchange in graduate medical education between medical schools in Latin America and institutions in the southeastern United States. There has been comparable interference with similar programs between institutions in the United States and those in the United Kingdom, Italy, Egypt, Saudi Arabia, Australia, and New Zealand. It is of interest that schools in countries which provide medical education comparable to that offered in the United States are most concerned about the restricted length of stay. From my meetings with various officials and medical leaders, I believe there is a consensus that the problems posed by the limited duration of stay are primarily educational and relate to the inability of trainees interested in high quality graduate medical education to remain for a sufficient period of time to obtain the education they require. One point which was emphasized by physicians from Venezuela was the hazards they expect will result if young Latin American physicians are forced to receive training in the Soviet Union and other countries where Marxist attitudes prevail.

Once again, from the ECFMG perspective, increasing the duration of stay to allow completion of a training objective would not jeopardize the intent of the law nor would it result in the classic brain- drain syndrome.

As you are aware, one of the recent amendments to PL 94-484 requires that exchange visitor alien physicians must make a commitment to return to their home country upon completion of training in the United States. This requirement, in addition to the controls ECFMG has over the issuance of the form (IAP-66), which allows exchange visitors to obtain a J-1 visa, would preclude the exchange visitor from remaining in this country indefinitely.

In addition, increasing the duration of stay would 1) probably do much to enhance our international relations with many countries who value the training that the United States has to offer and 2) would also benefit hospitals which are currently depending upon the substantial disruption waiver provision of the law to carry them through the transition period.

PERMISSION TO CHANGE TRAINING OBJECTIVE

An alien physician who enters the United States as an Exchange Visitor to participate in an accredited graduate medical education training program is required to provide a letter from his home country government stipulating that there is a need in that country for physicians with the type of training that the alien is seeking. Furthermore, the home country government must also certify that the alien has filed a written assurance with the government of his country that he will return upon completion of training in the United States and intends to enter the practice of medicine in the specialty for which the training is being sought. That training program is the training objective.

Although most alien physicians who enter the United States as Exchange Visitor Foreign Medical Graduates adhere to their initial training objective, complete it and return home, some trainees (and some countries) learn that the initial objective is not appropriate. This can occur for a wide variety of reasons. Under the Memorandum of Understanding between the International Communication Agency and ECFMG, the alien trainee is permitted to make one change in his training objective, but only with the agreement of his home country government, as described above. The present three-year maximum stay for Exchange Visitors, as specified in the provisions of Public Law 94-484, discourages alien physicians from making changes in their training objectives, since a three-year stay does not provide enough time for a valid educational experience. If the duration of stay for Exchange Visitors is increased, alien physician EVFMGs should be limited to only one change of objective and that should take place no later than the end of the second year of participation in the Exchange Visitor program, and only with the agreement of the aliens' home country governments .

With such caveats, alien physicians' changes in their training objectives should not contribute to abuse of the Exchange Visitor Program.

SPECIALTY CERTIFICATION

The Educational Commission for Foreign Medical Graduates is not directly involved in the process of licensure to practice medicine in the United States. Nonetheless, as a licensed physician, holding a valid certificate issued by a constituent board of the American Board of Medical Specialties, I believe that it is important to delete "specialty certification" from the provisions of the Public Law 95-83 amendment to the Immigration and Nationality Act. Specialty certification has little to do with licensure to practice medicine in the United States.

This concludes my prepared statement. I will be pleased to answer questions of the Chairman and Members of the Subcommittee.

Respectfully submitted,

Ray L. Casterline, M.D.

SUBSTANTIAL DISRUPTION WAIVERS - 1978

STATE	PROGRAM	NUMBER REQUESTED	NUMBER APPROVED
Arizona	General Surgery	2 T1 *	0
Colorado	Pediatrics	2 T1	2 T1
Connecticut	General Surgery	4 T1	0
Illinois	Pediatrics	1 T1	0
Louisiana	Internal Medicine	1 T1	0
Maryland	Pediatrics	1 T1	1 T1
Michigan	Pediatrics	1 T1	0
	Psychiatry	1 T1	1 T1
Missouri	Psychiatry	1 T1	1 T1
New Mexico	Neurology	1 T1	1 T1
New York	General Surgery	3 T1	3 T1
	Pathology	1 T1	1 T1
	Pediatrics	5 T1	1 T1
	Psychiatry	4 T1	4 T1
	Therapeutic Radiology	2 T1	2 T1
North Carolina	General Surgery	1 T1	0
	Neurosurgery	1 T1	0
Ohio	Ob/Gyn	1 T1	1 T1
Pennsylvania	General Surgery	1 T1	1 T1
Puerto Rico	Internal Medicine	1 T1	0
	TOTAL	35	19

*T1 = Tier 1

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SUBSTANTIAL DISRUPTION WAIVERS - 1979

STATE	PROGRAM	NUMBER REQUESTED	NUMBER APPROVED
Connecticut	Pediatrics	1 T1 *	1 T1
	Psychiatry	1 T1	0
		4 T2 **	4 T2
Georgia	Pathology	1 T1	1 T1
Illinois	Anesthesiology	1 T2	1 T2
	General Practice	1 T1	0
	Psychiatry	1 T1	1 T1
Massachussetts	Anesthesiology	2 T2	0
	General Surgery	1 T1	1 T1
	Neurosurgery	1 T2	1 T2
Michigan	General Practice	1 T1	0
	General Surgery	1 T2	0
	Pediatrics	5 T1	2 T1
New Jersey	Internal Medicine	1 T1	0
		3 T2	0
	Pediatrics	1 T2	0
New York	Anesthesiology	6 T1	6 T1
		8 T2	6 T2
	General Surgery	6 T1	6 T1
	Internal Medicine	9 T1	0
	Neurology	6 T2	6 T2
	Pathology	2 T1	2 T1
		2 T2	2 T2
	Pediatrics	20 T1	20 T1
		30 T2	30 T2
	Psychiatry	2 T1	2 T1
		7 T2	4 T2
	Therapeutic Radiology	1 T2	1 T2

Substantial Disruption Waivers - 1979

Ohio	Anesthesiology	1 T1	1 T1
	Family Practice	1 T1	1 T1
	General Surgery	1 T1	1 T1
	Internal Medicine	3 T1	3 T1
	Neurology	1 T2	1 T2
	Psychiatry	1 T1	1 T1
	Therapeutic Radiology	1 T2	1 T2
Pennsylvania	Opthalmology	1 T2	1 T2
	Psychiatry	1 T2	0
Tennessee	Internal Medicine	2 T2	0
Texas	Pediatrics	1 T1	0
Washington, D.C.	Pathology	1 T1	1 T1
	TOTAL	140	108

* T1 = Tier 1

** T2 = Tier 2 Appeal Level

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SUBSTANTIAL DISRUPTION WAIVERS - 1980

STATE	PROGRAM	NUMBER REQUESTED	NUMBER APPROVED
Missouri	Urology	1 T2 **	0
New Jersey	Pediatrics	20 T2	20 T2
New York	Anesthesiology	20 T2	20 T2
	Child Psychiatry	3 T2	3 T2
	General Surgery	12 T2	12 T2
	Internal Medicine	1 T1 *	1 T1
		20 T2	19 T2
	Pathology	2 T1	2 T1
		3 T2	3 T2
	Pediatrics	5 T1	5 T1
		63 T2	63 T2
		5 T2	Pending
	Physical Medicine	7 T2	7 T2
	Psychiatry	16 T2	13 T2
Ohio	Pathology	1 T2	0
	Pediatrics	2 T2	Pending
	Therapeutic Radiology	1 T1	1 T1
Pennsylvania	Pediatrics	1 T2	0
Tennessee	Psychiatry	1 T1	1 T1
Washington, D.C.	Therapeutic Radiology	2 T2	2 T2
	TOTAL	186	172

* T1 = Tier 1
**T2 = Tier 2 Appeal Level

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EDUCATIONAL COMMISSION for FOREIGN MEDICAL GRADUATES

3624 MARKET STREET, PHILADELPHIA, PENNSYLVANIA 19104, U.S.A. ☐ PHONE: 215 [illegible] ☐ CABLE: EDCOUNCIL, PHILADELPHIA

February 19, 1980

MEMORANDUM

TO: United States Medical School Deans
Hospital Administrators
Institutional Directors of Medical Education
Graduate Medical Education Training Program Directors
and Training Program Liaison Personnel

FROM: Executive Director, ECFMG

SUBJECT: Background Information and Application Procedures for Substantial Disruption Waivers

Last April, I mailed a memorandum describing amendments to the Immigration and Nationality Act in which the Congress applied stringent requirements for the issuance of J-1 (Exchange Visitor) Visas to alien physicians. Congress then provided for the waiver of certain portions of those requirements, if rigorous implementation of all of the provisions of that section of the law would cause a "substantial disruption in health services."

I am enclosing recently-revised background material, instructions and application forms graduate medical education training programs or institutions may use to apply for substantial disruption waivers. The extensive revisions resulted from the joint efforts of the Educational Commission for Foreign Medical Graduates and officials of the Division of Medicine, Bureau of Health Manpower, Health Resources Administration, Department of Health, Education, and Welfare. We believe that the revisions will enable you to gain a better understanding of the waiver mechanism and application procedures.

If you have questions about any aspect of the substantial disruption waiver process, ECFMG will be pleased to respond to your queries and to provide any assistance you may need.

Ray L. Casterline, M.D.

RLC:eg
Enclosures

SUBSTANTIAL DISRUPTION WAIVER APPLICATION

PART I - BACKGROUND

Requirements for Issuance of Exchange Visitor (J-1) Visas

Recent amendments to the Immigration and Nationality Act, contained in Public Laws 94-484 and 95-83, require the application of stringent requirements for issuing Exchange Visitor (J-1) Visas to alien physicians who seek to enter the United States to participate in accredited programs of graduate medical education or training.

In brief, these requirements are

(A) an accredited school of medicine, or any one or more of its affiliated hospitals, must agree in writing to provide or assume responsibility for the graduate medical education or training;

(B) the alien physician must pass the Visa Qualifying Examination (VQE), must demonstrate competency in oral and written English, must be able to adapt to the educational and cultural environment in which he will be receiving his training, and must have adequate prior education for successful participation in the program;

(C) the alien must make a commitment to return to his home country upon completion of training in the United States, and his country must provide written assurance that there is need for the alien's services in his country (Attachment 3); and

(D) the alien will be allowed to stay in this country no more than 2 years, unless additional time is specifically requested by his country for a maximum of one additional year. The extension is for the purpose of continuing the alien's education or training under the specific program for which he or she came to the United States.

Requirement (B) above does not pertain to a graduate of a school accredited by the Liaison Committee on Medical Education. Hence, alien graduates of accredited U.S. or Canadian medical schools are not affected by this requirement. Moreover, an alien physician who was fully licensed to practice medicine in a State on January 9, 1977, held a valid specialty certificate issued by a component board of the American Board of Medical Specialties, and was actually practicing medicine in a State on that date will be considered to have met the examination requirements in (B) above.

The stated intent of these amendments is to decrease reliance on alien physicians and to assure quality medical care for individuals served by these physicians during their participation in graduate medical education training programs.

Substantial Disruption

Because of the expected severe reduction in the number of alien physicians entering the United States annually as a result of these amendments to the law, the Congress provided for waiver of two of these requirements on a case-by-case basis, if a graduate medical education program can demonstrate that application of these requirements would result in a "substantial disruption" of health services.

Under a substantial disruption waiver, an Exchange Visitor Foreign Medical Graduate (EVFMG) is not required to:

1. have an accredited school of medicine, or any one or more of its affiliated hospitals provide the graduate medical education; and

2. pass the Visa Qualifying Examination.

However, an alien physician entering under a substantial disruption waiver must hold ECFMG certification and meet all of the other requirements for issuance of Form IAP-66 (formerly DSP-66) to qualify for an Exchange Visitor (J-1) Visa.

Congress also provided that in no case will these waivers result in a number to exceed the total number of alien physicians participating in programs of graduate medical education or training in the United States on January 10, 1978.

Substantial Disruption Waiver Mechanism

The substantial disruption waiver was developed to permit programs and institutions traditionally placing significant reliance on alien physicians a transition period during which placement of such physicians may continue, but in decreasing numbers. During this transition period, extending through December 31, 1980, programs and institutions are expected to develop alternative provider resources and attract primarily graduates of American medical schools.

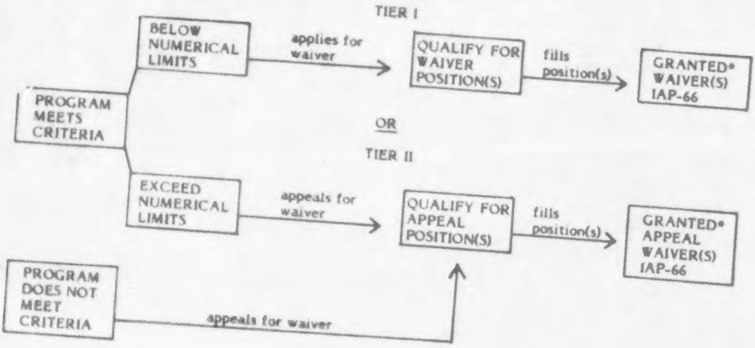
To put the waiver mechanism into effect, the Department of Health, Education, and Welfare (HEW) developed: 1) eligibility criteria to identify programs and institutions affected by these provisions and 2) decreasing numerical limits to permit programs and institutions a gradual rate of phase out for dependency on alien physicians while developing alternative provider resources.

To assist programs or institutions which have a substantial disruption of health services but do not meet the routine specifications developed by HEW, the waiver mechanism provides for an appeal process. A Federal Substantial Disruption Waiver Appeal Board has been established to consider appeals from these programs and institutions.

In essence the waiver mechanism provides for two tiers of waiver application. Tier I is for programs and institutions which meet the eligibility criteria and are requesting waivers within the numerical limitations. Tier II is for programs and institutions which 1) meet the eligibility criteria but are requesting waivers in excess of the numerical limitations or 2) do not meet the eligibility criteria and can demonstrate a need for waivers based on a substantial disruption of health services.

ECFMG has been designated by federal authorities to process waiver requests and to submit appeal applications to the Federal Board. ECFMG is available for consultation and will provide assistance to programs and institutions at their request.

WAIVER MECHANISM FLOW CHART


TIER I
BELOW NUMERICAL LIMITS
applies for waiver
QUALIFY FOR WAIVER POSITION(S)
fills position(s)
GRANTED* WAIVER(S) IAP-66
PROGRAM MEETS CRITERIA
OR
TIER II
EXCEED NUMERICAL LIMITS
appeals for waiver
QUALIFY FOR APPEAL POSITION(S)
fills position(s)
GRANTED* APPEAL WAIVER(S) IAP-66
PROGRAM DOES NOT MEET CRITERIA
appeals for waiver

Substantial Disruption Waiver Guidelines

When determining eligibility status and the numerical limits, programs must count all alien physicians in the program on January 10, 1978 regardless of visa status, or date of entry into the program.

Programs may submit waiver applications either before or after interviewing alien physicians to fill positions.

Programs may fill waived positions any time during the calendar year, but any unused waived positions may not be carried over into a subsequent calendar year.

Programs or institutions granted* waivers may not subsequently recruit, in excess of the numerical limits, alien physicians who have met the new requirements of the law. However, programs or institutions do have the option to utilize such alien physicians in lieu of filling waived positions.

Waivers may be granted for alien physicians entering training programs, so that on December 31 of the respective calendar year, the limits established for that year will not be exceeded.

If no waivers are granted, there is no numerical restriction on the recruiting of alien physicians who have met the new requirements of the law.

Please note: Only those programs utilizing waived positions are restricted by the numerical limits and only for that year in which waiver(s) were first granted.

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*Granted - A waiver will be considered to have been granted only upon issuance of a Certificate of Eligibility (Form IAP-66 formerly DSP-66) for the alien physician selected to fill the position.

Length of Validity for Waived J-1 Visa Holders

An individual who obtains a J-1 visa under a waiver may remain in this country without further waiver review for two years, and for one additional year, if the third year is requested by the home country government. However, an individual must apply to ECFMG each year for continuation of Exchange Visitor Sponsorship (IAP-66). Also, waived J-1 visa holders must be counted in determining the program's eligibility for future waivers.

Since waivers are assigned to programs and/or institutions, individual EVFMGs cannot transfer from waived positions to non-waived positions without meeting the new requirements of the law and do so at the risk of loss of their J-1 visa (Exchange Visitor) status.

Criteria for Eligibility and Numerical Limits

The four eligibility categories and their corresponding numerical limits are described below. The rate of phase-out of dependence on alien physicians varies with the category and is consistent with the anticipated impact such phase-out will have on the provision of services as well as the ability of the programs to find alternative resources.

Category A

Eligibility Criteria

For accredited graduate medical education training programs in anesthesiology, child psychiatry, general practice, nuclear medicine, pathology, pediatrics, physical medicine, psychiatry, or therapeutic radiology, which had more than 25 percent of all their positions occupied by alien physicians on January 10, 1978.

Numerical Limits

> In 1980, the total number of J-1 visa holders in each program may not exceed 80 percent of the number of J-1 visa holders on January 10, 1978, and the total number of alien physicians in the program may not exceed 70 percent of the number of alien physicians on January 10, 1978.

Category B

Eligibility Criteria

For accredited graduate medical education training programs in specialties other than those described in Category A above which had more than 25 percent of all their positions occupied by alien physicians on January 10, 1978, AND which provide 50 percent or more of their full time equivalent training in a facility located in a primary medical care manpower shortage area, designated under Section 332 of the Public Health Service Act, or had more than 25 percent Medicaid Patients in calendar year 1977.

Numerical Limits

> In 1980, the total number of J-1 visa holders in each program may not exceed 80 percent of the number of J-1 visa holders on January 10, 1978, and the total number of alien physicians in the program may not exceed 70 percent of the number of alien physicians on January 10, 1978.

Category C

Eligibility Criteria

For accredited graduate medical education training programs which are in specialties or locations other than those described in Categories A or B and had more than 50 percent of all of their positions occupied by alien physicians on January 10, 1978.

Numerical Limits

In 1980, the total number of J-1 visa holders in each program may not exceed 60 percent of the number of J-1 visa holders on January 10, 1978, and the total number of alien physicians in the program may not exceed 40 percent of the number of alien physicians on January 10, 1978.

Special Note: Training programs under Categories A, B, and C which are conducted in more than one facility as integrated programs and which obtain a waiver for one or more positions must maintain the same percentage of training positions among the participating facilities as was the case on January 10, 1978.

Category D

Eligibility Criteria

A hospital (a) which had more than 25 percent alien physicians, in total, in its training programs conducted solely within its facilities, on January 10, 1978, AND (b) which is located in a primary medical care manpower shortage area designated under Section 332 of the Public Health Service Act, or had more than 25 percent Medicaid patients in calendar year 1977, may apply for and obtain waivers for those training programs conducted solely within the institution, distributed among such programs at its discretion.

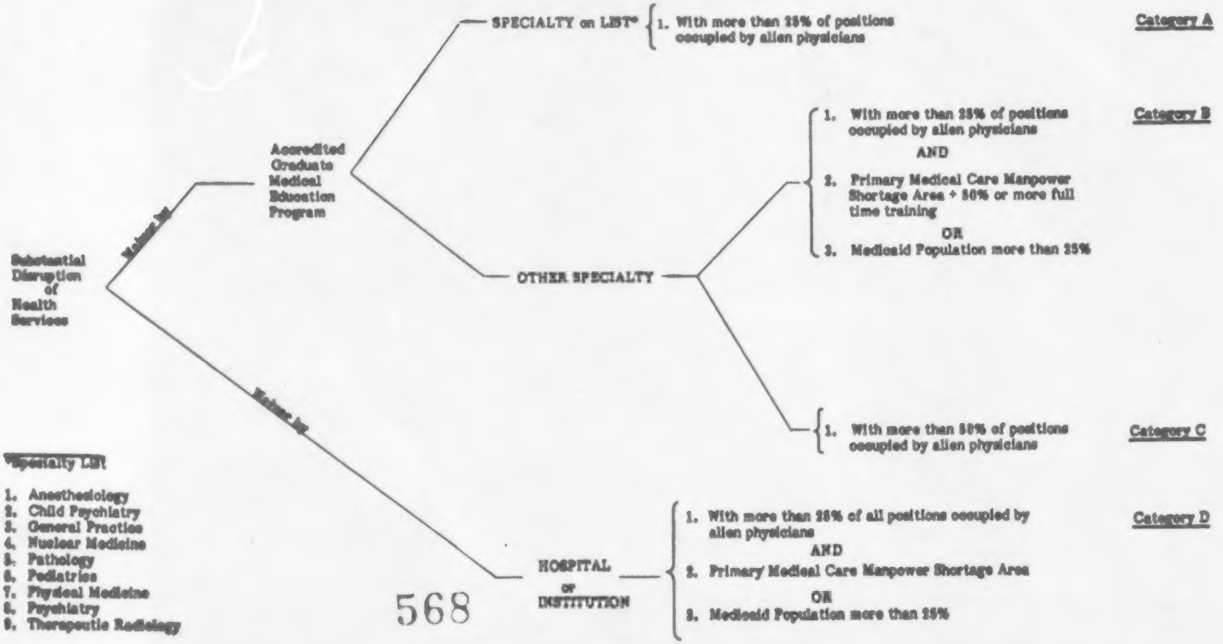
Numerical Limits

In 1980, the total number of J-1 visa holders in such programs may not exceed 80 percent of the total number of J-1 visa holders on January 10, 1978, and the total number of alien physicians in such programs may not exceed 70 percent of the number of alien physicians on January 10, 1978.

A diagram summarizing the eligibility criteria in each category follows.

ELIGIBILITY CRITERIA SUMMARY

Waiver Request For Substantial Disruption of Services


Substantial Disruption of Health Services
Waiver by
Accredited Graduate Medical Education Program
SPECIALTY on LIST*
OTHER SPECIALTY
Waiver by
HOSPITAL or INSTITUTION

SPECIALTY on LIST*

1. With more than 25% of positions occupied by alien physicians

Category A

OTHER SPECIALTY

1. With more than 25% of positions occupied by alien physicians

AND

2. Primary Medical Care Manpower Shortage Area + 50% or more full time training

OR

3. Medicaid Population more than 25%

Category B

1. With more than 50% of positions occupied by alien physicians

Category C

HOSPITAL or INSTITUTION

1. With more than 25% of all positions occupied by alien physicians

AND

2. Primary Medical Care Manpower Shortage Area

OR

3. Medicaid Population more than 25%

Category D

*Specialty List

1. Anesthesiology
2. Child Psychiatry
3. General Practice
4. Nuclear Medicine
5. Pathology
6. Pediatrics
7. Physical Medicine
8. Psychiatry
9. Therapeutic Radiology

Waiver Appeals

Present policy provides for an appeal process for programs or institutions most severely affected by the new requirements for entry of alien physicians as Exchange Visitors. These programs or institutions may have met the eligibility criteria but require waivers in excess of the numerical limits or they may not have met the eligibility criteria and were therefore automatically excluded from obtaining waivers under the Tier I process.

Favorable Action by the Waiver Appeal Board on applications will be based on clear and convincing evidence that, without such waivers, a severe "substantial disruption" of health services would result. These applications must include a full and detailed discussion of the specific problems that programs or institutions anticipate without such waivers, what alternative provider resources and methods have been sought to meet the deficit in health services, and what specific plan will be followed for phasing down, year-by-year, the reliance on alien physicians.

Waiver Application Review Process

There are two tiers of applications and review for waivers:

Tier I - Programs and institutions which meet the eligibility criteria (page 6) and are within the numerical limits may submit applications for waivers such that the number of waivers requested will not result in exceeding the maximum number of alien physicians and J-I visa holders permissible for that category. ECFMG will be the receipt point for these applications, and will review and process the applications under the numerical limits established for each category.

Tier II - Appeal applications are to be mailed to ECFMG for initial processing. ECFMG will forward appeal applications to the Health Resources Administration of the Department of Health, Education, and Welfare for consideration. A Federal Substantial Disruption Waiver Appeal Board consisting of seven Federal members has been established to review these applications. The appeal board will determine whether programs qualify for additional waivers.

* * * * *

ECFMG will notify programs or institutions when it has been determined that they have qualified for waived positions. A waiver will be considered to have been granted only upon issuance of a Certificate of Eligibility (Form IAP-66) by ECFMG.

ECFMG will issue Certificates of Eligibility only to alien physicians who hold ECFMG Certification and meet other requirements to qualify for Exchange Visitor Visas, including Foreign Government Letters of Assurance of Need (See Attachment 3).

ECFMG will notify the Liaison Committee on Graduate Medical Education (LCGME) of all programs granted waivers. The concern of LCGME and ECFMG is that graduate medical education training programs provide high quality educational programs, which will permit Exchange Visitors to accomplish their training objectives within the limitations of time allowed under the law.

If you have questions or need further clarification, you may contact ECFMG for assistance.

ECFMG
3624 Market Street
Philadelphia, Pa. 19104
Telephone: Area Code 215: 386-5900

PART II - WAIVER APPLICATION PROCEDURE

Applying for a waiver, under any category, will consist of retrieving and compiling information and performing basic percentage calculations. Once you have reviewed all of the information, and are ready to request a waiver, follow these procedures.

Tier I - Waiver Application

1. Select the category (or categories) that best serve your situation based on the diagram summarizing the eligibility criteria (see page 6).

2. Obtain the information that you will need from any one or more of the following sources:

ECFMG	a)	number of J-1 visa holders under ECFMG sponsorship in training programs on January 10, 1978
Hospital Administration	a)	Medicaid population figures for inpatient admissions for calendar year 1977
	b)	total number of inpatient admissions for calendar year 1977
	c)	primary medical care manpower shortage area designation information
Health Systems Agency or State Health Planning and Development Agency	a)	primary medical care manpower shortage area designation information
Hospital Director of Medical Education or Program Director	a)	number of alien physicians in training programs
	b)	percentage of training time provided in physician shortage area

3. Select the appropriate Waiver Application(s). For example, if applying for a Waiver under Category B, please use the application labeled Category B. Copies of Waiver Applications are appended.

4. Be sure to complete each of the four sections of the waiver application. An application will not be processed if it is incomplete or filled out incorrectly.

5. When calculating percentages in Section II Determination of Eligibility, a fraction will be considered to have exceeded the previous whole number.

   e.g. 25.1% will be considered to be greater than 25%

When calculating numerical limits in Section III Calculation of Numerical Limits, if a fraction occurs, do not raise it to the next highest whole number.

e.g. 50% of 75 = 37.5
37 is the acceptable figure, not
37.5 or 38

6. In all categories, when calculating the number of alien physicians, include all non-United States citizen medical school graduates regardless of visa status (immigrant/non-immigrant) or location of medical school of graduation (includes alien graduates of United States and Canadian medical schools).

7. Forward the completed Waiver Application to ECFMG.

Tier II - Waiver Appeal Applications

A. For programs or institutions which meet the eligibility criteria described in Categories A, B, C, or D and require waived positions beyond the established numerical limits (see Waiver Application, Section III, line C and D):

   1. Complete a Tier I Waiver Application in accordance with the instructions above.

   2. Complete a Tier II Waiver Appeal Application providing the information requested in detail. Supporting documentation is essential.

   3. Complete the Population and Distribution of Trainees Data Display through calendar year 1981.

   4. Forward the Application(s), the Population and Distribution of Trainees Data Display(s) and the Narrative(s) to ECFMG.

B. For programs or institutions which are not eligible for Categories A, B, C, or D:

   1. Complete a Category E Waiver Application Form.

   2. Complete a Tier II Waiver Appeal Application providing the information requested in detail. Supporting documentation is essential.

   3. Complete the Population and Distribution of Trainees Data Display through calendar year 1981.

   4. Forward the Application(s), the Population and Distribution of Trainees Data Display(s) and the Narrative(s) to ECFMG.

ECFMG will be responsible for transmitting applications for appeals to the Federal Substantial Disruption Waiver Appeal Board chaired by the Administrator, Health Resources Administration, Department of Health, Education, and Welfare.

Please note, an incomplete appeal application will not be transmitted to the Waiver Appeal Board for consideration.

Part III - Attachments

1. Waiver Applications (Categories A, B, C, D, and E)
2. Waiver Appeal Application and Population and Distribution of Trainees Data Display
3. Foreign Government Letter of Assurance of Need

NOTE: The attached blank application forms are to be used as masters.

SUBSTANTIAL DISRUPTION OF HEALTH SERVICES

TIER I - WAIVER APPLICATION FOR CALENDAR YEAR 1980

CATEGORY A

Training Programs in Anesthesiology, Child Psychiatry, General Practice, Nuclear Medicine, Pathology, Pediatrics, Physical Medicine, Psychiatry, and Therapeutic Radiology.

Complete one form for each applicable program.

I. Identification

Institution:______________________________JCAH Number______

Address:____

Training Program
Responsible Official:__________________________Phone:__________

Program:______________________________

Is this an integrated program at more than one facility: YES______NO_____

If Yes, list all facilities utilized on a continuation sheet and describe the program in terms of number of residents and time spent at each site.

II. Determination of Eligibility

If more than 25 percent of the positions in an approved training program in a specialty listed below were occupied by alien physicians* on January 10, 1978, the training program may apply for a Category A waiver for that specialty: Anesthesiology, Child Psychiatry, General Practice, Nuclear Medicine, Pathology, Pediatrics, Physical Medicine, Psychiatry, and Therapeutic Radiology.

A. Total Number of Positions Occupied on January 10, 1978 at all levels of the Training Program (PGY I, II, etc.) __________

B. Total Number of Positions Occupied By Alien Physicians on January 10, 1978 (This number includes permanent, H and J-1 visa holders) __________

C. Line B/line A x 100% (must exceed 25%) __________

If you meet the eligibility criteria, proceed to Section III.

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*Alien Physicians: All non-United States citizen medical school graduates.

III. Calculation of Numerical Limits

For each training program meeting eligibility criteria to apply for a waiver under Section II above:

A. Total Number of J-1 Visa Holders In This Program on January 10, 1978. ________

B. Total Number of Alien Physicians In This Program on January 10, 1978. (This number includes permanent, H, and J-1 visa holders) ________

Limits for 1980:

C. J-1 Visa Holders Line A x 80%= ____

D. Alien Physicians Line B x 70%= ____

IV. Waiver Request

Waivers are requested for this program in the following numbers for 1980. These must be within the limits determined under Section III above.

A. Number of J-1 Visa Waivers Requested for 1980 ________

B. Number of J-1 Visa Holders With Waivers From Prior Years Projected on December 31, 1980 ________

C. Number of J-1 Visa Holders Not Holding Waivers Projected On December 31, 1980 ________

D. Number of other Alien Physicians Not Holding Waivers Projected On December 31, 1980. (This number includes permanent and H visa holders) ________

E. Line A + Line B + Line C (Cannot exceed Section III, Line C, 1980) ________

F. Line A + Line B + Line C + Line D (Cannot exceed Section III, Line D, 1980) ________

If the figures in lines E or F exceed the numerical limits established in Section III, lines C or D, submit an appeal application with this form for the number of J-1 visa positions desired in excess of the established limits.

SUBSTANTIAL DISRUPTION OF HEALTH SERVICES

TIER I - WAIVER APPLICATION FOR CALENDAR YEAR 1980

CATEGORY B

Training Programs Other Than Anesthesiology, Child Psychiatry, General Practice, Nuclear Medicine, Pathology, Pediatrics, Physical Medicine, Psychiatry, and Therapeutic Radiology.

Complete one form for each applicable program.

I. Identification

Institution:______________________________ JCAH Number:________

Address:____

Training Program
Responsible Official:__________________________ Phone:__________

Program:_____________________________

Is this an integrated program at more than one facility: YES______ NO______

If Yes, list all facilities utilized on a continuation sheet and describe the program in terms of number of residents and time spent at each site.

II. Determination of Eligibility

If more than 25 percent of the positions in an approved training program in a specialty other than those listed in Category A were occupied by alien physicians* on January 10, 1978, AND provide 50 percent or more of their full-time equivalent training in a facility located in a primary medical care manpower shortage area or had more than 25 percent Medicaid patients in calendar year 1977, the training program may apply for a Category B waiver for that specialty.

A program must qualify under (1) AND either (2) or (3).

1. Percent Training Positions.

A. Total Number of Positions Occupied on January 10, 1978 at all levels of the Training Program ______

B. Total Number of Positions Occupied By Alien Physicians on January 10, 1978 (This number includes permanent, H and J-1 visa holders) ______

C. Line B/Line A x 100% (must exceed 25%) ______

---

*Alien Physicians: All non-United States citizen medical school graduates.

AND

2. Percent time in physician shortage area, as defined by Section 332 of the Public Health Service Act.

   A. Total Number of Weeks in Educational Program ______

   B. Number of Weeks of A in Physician Shortage Area ______

   C. Line B/Line A x 100% (must be 50% or more) ______

   D. Provide a narrative statement of i) educational program; ii) types of training and locations of physician shortage areas in terms of Section 332

OR

3. Percent Medicaid Patients

   A. Total Number of Inpatient admissions* from January 1, 1977 - December 31, 1977 ______

   B. Total Number of Medicaid Inpatient admissions* from January 1, 1977 - December 31, 1977 ______

   C. Line B/Line A x 100% (must exceed 25%) ______

If you meet the eligibility criteria, proceed to Section III

III. Calculation of Numerical Limits

For each training program meeting eligibility criteria to apply for a waiver under Section II above:

   A. Total Number of J-1 Visa Holders in This Program on January 10, 1978 ______

   B. Total Number of Alien Physicians in This Program on January 10, 1978 (This number includes permanent, H, and J-1 visa holders) ______

Limits for 1980

   C. J-1 Visa Holders Line A x 80%=____

   D. Alien Physicians Line B x 70%=____

*Inpatient Admissions: Includes each time an individual enters the institution through a routine admission process. Short term holding in the emergency room for observation will not qualify under this definition. Actual admission for diagnostic and/or therapeutic procedures are countable.

IV. Waiver Request

Waivers are requested for this program in the following numbers for 1980. These must be within the limits determined under Section III above.

A. Number of J-1 Visa Waivers Requested for 1980 ____

B. Number of J-1 Visa Holders With Waivers From Prior Years projected on December 31, 1980 ____

C. Number of J-1 Visa Holders Not Holding Waivers projected on December 31, 1980 ____

D. Number of other Alien Physicians Not Holding Waivers projected on December 31, 1980 (This number includes permanent and H visa holders) ____

E. Line A + Line B + Line C (Cannot exceed Section III, Line C., 1980) ____

F. Line A + Line B + Line C + Line D (Cannot exceed Section III, Line D., 1980) ____

If the figures in lines E or F exceed the numerical limits established in Section III, lines C or D, submit an appeal application with this form for the number of J-1 visa positions desired in excess of the established limits.

SUBSTANTIAL DISRUPTION OF HEALTH SERVICES

TIER I - WAIVER APPLICATION FOR CALENDAR YEAR 1980

CATEGORY C

Training Programs Other Than Anesthesiology, Child Psychiatry, General Practice, Nuclear Medicine, Pathology, Pediatrics, Physical Medicine, Psychiatry, and Therapeutic Radiology.

Complete one form for each applicable program.

I. Identification

Institution:________________________________ JCAH Number:__________

Address:____

Training Program
Responsible Official:________________________________ Phone:____________

Program:________________________________

Is this an integrated program at more than one facility: YES______ NO______

If Yes, list all facilities utilized on a continuation sheet and describe the program in terms of number of residents and time spent at each site.

II. Determination of Eligibility

If more than 50 percent of the positions in an approved training program in any specialty other than on the list were occupied by alien physicians* on January 10, 1978, the training program may apply for a Category C waiver.

A. Total Number of Positions Occupied On January 10, 1978 at all levels of the training program ______

B. Total Number of Positions Occupied By Alien Physicians on January 10, 1978 (This number includes permanent, H and J-1 visa holders) ______

C. Line B/Line A x 100% (must exceed 50%) ______

If you meet the eligibility criteria, proceed to Section III.

III. Calculation of Numerical Limits

For each training program meeting eligibility criteria to apply for a waiver under Section II above:

A. Total Number of J-1 Visa Holders in This Program on January 10, 1978 ______

B. Total Number of Alien Physicians in This Program on January 10, 1978 (This number includes permanent, H, and J-1 visa holders) ______

---

*Alien Physicians: All non-United States citizen medical school graduates.

Limits for 1980:

C. J-1 Visa Holders Line A x 60%= ____

D. Alien Physicians Line B x 40%= ____

IV. Waiver Request

Waivers are requested for this program in the following numbers for 1980. These must be within the limits determined under Section III above.

A. Number of J-1 Visa Waivers Requested for 1980 ____

B. Number of J-1 Visa Holders With Waivers from Prior Years Projected On December 31, 1980 ____

C. Number of J-1 Visa Holders Not Holding Waivers Projected On December 31, 1980 ____

D. Number of Other Alien Physicians Not Holding Waivers Projected On December 31, 1980 (This number includes permanent and H visa holders) ____

E. Line A + Line B + Line C (Cannot exceed Section III, Line C, 1980) ____

F. Line A + Line B + Line C + Line D (Cannot exceed Section III, Line D, 1980) ____

If the figures in lines E or F exceed the numerical limits established in Section III, lines C or D, submit an appeal application with this form for the number of J-1 visa positions desired in excess of the established limits.

SUBSTANTIAL DISRUPTION OF HEALTH SERVICES

TIER I - WAIVER APPLICATION FOR CALENDAR YEAR 1980

CATEGORY D

Hospital Request for Programs Conducted Solely Within Its Facilities.

I. Identification

Hospital:______________________________ JCAH Number__________

Address:____

Training Program
Responsible Official:______________________ Phone:__________

Programs: (list all programs conducted solely within a hospital's facilities which are to be included in waiver request.)

____

____

____

(Use continuation sheets, if necessary.)

II. Determination of Eligibility

If a hospital had more than 25 percent alien physicians* in total, in its training programs conducted solely within its facilities, on January 10, 1978, AND is located in a primary medical care manpower shortage area or had more than 25 percent Medicaid patients in calendar year 1977, the hospital may apply for a Category D Waiver.

A program must qualify under 1 AND either 2 or 3

1. Percent Training Positions

A. Total Number of Training Positions Occupied at all Levels in Programs Conducted Solely Within the Facilities on January 10, 1978 ______

B. Total Number of Positions Occupied by Alien Physicians in these Programs on January 10, 1978 (This number includes permanent, H and J-1 visa holders) ______

C. Line B/Line A x 100% (must exceed 25%) ______

---

*Alien Physicians: All non-United States citizen medical school graduates.

AND

2. Check if hospital is located in a physician shortage area as defined by Section 332 of the Public Health Service Act ______

Provide location description in terms of Section 332

OR

3. Percent Medicaid Patients

   A. Total Number of Inpatient Admissions* from January 1, 1977 - December 31, 1977 ______

   B. Total Number of Medicaid Inpatient Admissions* from January 1, 1977 - December 31, 1977 ______

   C. Line B/Line A x 100% (must exceed 25%) ______

If you meet the eligibility criteria, proceed to Section III.

III. Calculation of Numerical Limits

For hospitals or institutions meeting eligibility criteria to apply for a waiver under Section II above:

A. Total Number of J-1 Visa Holders in These Programs on January 10, 1978 ______

B. Total Number Alien Physicians in These Programs on January 10, 1978 (This number includes permanent, H, J-1 visa holders) ______

Limits for 1980

C. J-1 Visa Holders Line A x 80%=____

D. Alien Physicians Line B x 70%=____

IV. Waiver Request

Waivers are requested for these programs at this hospital in the following numbers for 1980. These must be within the limits determined under Section III above.

---

*Inpatient Admissions: Includes each time an individual enters the institution through a routine admission process. Short term holding in the emergency room for observation will not qualify under this definition. Actual admission for diagnostic and/or therapeutic procedures are countable.

		Residency Code Number				Total
	Identify:	___	___	___	___	
A.	Number of J-1 Visa Waivers Requested for 1980	___ +	___ +	___ +	___	+ ___
B.	Number of J-1 Visa Holders With Waivers From Prior Years Projected on December 31, 1980	___ +	___ +	___ +	___	= ___
C.	Number of J-1 Visa Holders Projected On December 31, 1980 Not Holding Waivers	___ +	___ +	___ +	___	= ___
D.	Number of Other Alien Physicians Projected on December 31, 1980, Not Holding Waivers (This number includes permanent and H visa holders)	___ +	___ +	___ +	___	= ___
E.	Line A + Line B + Line C (Cannot exceed Section III, Line C, 1980)	___ +	___ +	___ +	___	= ___
F.	Line A + Line B + Line C + Line D (Cannot exceed Section III, Line D, 1980)	___ +	___ +	___ +	___	= ___

Note: In Section IV, if identifying more than 4 programs, make additional lines or use a continuation sheet.

If the figures in lines E or F exceed the numerical limits established in Section III, lines C or D, submit an appeal application with this form for the number of J-1 visa positions desired in excess of the established limits.

SUBSTANTIAL DISRUPTION OF HEALTH SERVICES

WAIVER APPLICATION FOR CALENDAR YEAR 1980

CATEGORY E

Training Programs which are not eligible for Categories A, B, C, or D.

Complete one form for each applicable program.

I. Identification

Institution:______________________________JCAH Number:__________

Address:____

Training Program
Responsible Official:__________________________Phone:____________

Program:____________________ ______

Is this an integrated program at more than one facility: YES______NO______

If Yes, list all facilities utilized on a continuation sheet and describe the program in terms of number of residents.

II. Background

1. Percent Training Positions

A. Total Number of Positions Occupied on January 10, 1978 at all levels of the Training Program ____________

B. Total Number of Positions Occupied By Alien Physicians* on January 10, 1978. (This number includes permanent, H and J-1 visa holders) ____________

C. Line B/Line A x 100% ____________

2. Percentage of full-time equivalent training in a facility located in a primary medical care manpower shortage area, as defined by Section 332 of the Public Health Service Act.

A. Total Number of Weeks in Educational Program ____________

B. Number of Weeks of A in Physician Shortage Area ____________

C. Line B/Line A x 100% ____________

---

*Alien Physicians: All non-United States citizen medical school graduates.

3. Number of Medicaid patients in calendar year 1977

A. Total Number of Inpatient admissions* from January 1, 1977 - December 31, 1977 ____________

B. Total Number of Medicaid Inpatient admissions* from January 1, 1977 - December 31, 1977 ____________

C. Line B/line A x 100% ____________

---

* Inpatient Admissions: Includes each time an individual enters the institution through a routine admission process. Short term holding in the emergency room for observation will not qualify under this definition. Actual admission for diagnostic and/or therapeutic procedures are countable.

SUBSTANTIAL DISRUPTION OF HEALTH SERVICES
WAIVER APPEAL APPLICATION FOR CALENDAR YEAR 1980

I. Identification

Institution:________________________________ JCAH Number:________

Address:____

Training Program
Responsible Official:__________________________ Phone:______________

Program:______________________________

Is this an integrated program at more than one facility: YES____ NO_____

If yes, list all facilities utilized on a continuation sheet and describe the program in terms of number of residents and time spent at each site.

Indicate the number of waived positions that will be necessary to meet the 1980 program requirements. ☐

II. Narrative Justification

To judge the needs of programs and institutions for substantial disruption waivers, the following issues and questions must be addressed in the narrative as they relate to the utilization of resident manpower.

1. Patient case load and service patterns utilized by the hospital.

    A. What was the patient case load in the base calendar year 1977 and in calendar year 1979: inpatient and outpatient?

    B. What is the projected patient case load for 1980: inpatient and outpatient?

    C. What are the treatment responsibilities of professional staff, particularly the residents, with respect to the identified patient case load?

2. Health service needs met by the program.

    A. What health service needs of the community are currently met by the program?

    B. If waivers were not granted how would this affect the patients served by the program and the level of services provided to them.

3. Alternatives and plans to phase down reliance on alien physicians.

    A. What efforts are being made to recruit U.S. medical school graduates and U.S. citizen foreign medical school graduates?

    B. What methods will be used to attract graduates of American medical schools in the future?

C. What non-physician manpower alternatives to alien physicians are being utilized?

D. If non-physician manpower alternatives are not being utilized but are planned, specify 1) implementation schedule, and 2) anticipated constraints/problems and plans for resolution.

E. What other alternatives are being considered such as, but not limited to, restructuring or integrating residency programs?

4. Indicate whether you qualified, in 1980, for waived positions to reach the numerical limits. If yes, indicate whether the 1980 waived positions under the pre-established limit have been filled.

III. Complete the attached data display.

POPULATION AND DISTRIBUTION OF TRAINEES DATA DISPLAY*

Directions

1. Complete the data display for each accredited training program or institution filing an appeal application.

2. In display I, indicate the number and distribution of trainees who were present on the Base Date, January 10, 1978 as categorized PG I, PG II, etc.

3. In display II, indicate the number and distribution of trainees who would be present on December 31, 1980. Indicate above the slash mark (/) the number in each category if no appeal waivers are qualified for in 1980. This figure should include all waived positions granted prior to 1980 and all Tier I waived positions qualified for in 1980. Indicate below the slash mark (/) the number anticipated in each category if the program should qualify for these 1980 appeal waivers.

4. In display III, indicate the number and distribution of trainees who would be present on December 31, 1981.

I. BASE: January 10, 1978

	Total	US Citizen		Alien Physicians			
	Prog	MG	FMG	Total	P	H	J
PG I							
PG II							
PG III							
PG IV							
PG V							
PG VI							
PG VII							
Total							

III. December 31, 1980 without/with waivers

	Total	US Citizen		Alien Physicians			
	Prog	MG	FMG	Total	P	H	J
PG I	/	/	/	/	/	/	/
PG II	/	/	/	/	/	/	/
PG III	/	/	/	/	/	/	/
PG IV	/	/	/	/	/	/	/
PG V	/	/	/	/	/	/	/
PG VI	/	/	/	/	/	/	/
PG VII	/	/	/	/	/	/	/
Total	/	/	/	/	/	/	/

IV. December 31, 1981

	Total	US Citizen		Alien Physicians			
	Prog	MG	FMG	Total	P	H	J
PG I							
PG II							
PG III							
PG IV							
PG V							
PG VI							
PG VII							
Total							

---

* The data display is to be filled out when making application for waiver appeals only.

SAMPLE

Name of Applicant for Visa: ______________________

There currently exists in (country) a need for qualified medical practitioners in the specialty of ______________

____

(Name of applicant for Visa) has signed a written assurance with the government of this country [illegible] he/she will return to this country upon completion of training in the United States and intends [illegible] enter the practice of medicine in the specialty for which training is being sought.

Stamp (official and signature)
of issuing official of named
country.

Dated:

____
Official of named Country

Attachment 3

Mr. **Waxman**. Thank you very much for your testimony. That last recommendation, I might point out, has been made part of the proposal that I have introduced.

How often is the VQE given and in how many sites around the world?

Dr. **Casterline**. It is given in 31 major cities of the world, on each of the continents, once each year.

Mr. **Waxman**. Who pays for the cost of administering the VQE exam?

Dr. **Casterline**. Examination fees are paid by the candidates who take it.

Mr. **Waxman**. What is your experience with VQE, how many people take it, how many times can it be taken, how many candidates pass, et cetera?

Dr. **Casterline**. There is no limit to the number of times VQE can be taken. I will read the VQE results data and leave this table for the record. The table shows the total number taking and pass rates for the 3 years that VQE has been given. I will summarize by saying that in 1977, 4,611 took it, 1,163 passed, a rate of 25 percent. In 1978, 3,217 took the examination, 945 passed for a pass rate of 29 percent. In 1979, 4,790 took VQE with a pass rate of 30 percent, 1,437 passed.

[The table referred to follows]:

VISA QUALIFYING EXAMINATION RESULTS

Year	Total taking	Pass—Day 1 Pass—Day 2		Pass—Day 1 Fail—Day 2		Fail—Day 1 Pass—Day 2		Fail—Day 1 Fail—Day 2		Visa qualified [1] ECFMG certified	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
1977	4,611	1,163	25	0	.0	1,943	42	1,505	33	710	15
1978	3,217	945	29	10	.3	1,692	53	570	18	668	21
1979	4,790	1,437	30	13	.2	2,137	45	1,203	25	967	20

[1] Represents number of applicants who at the time of result letters met the requirements for ECFMG certification and the examination requirements to obtain a visa.

Mr. **Waxman**. Is the failure rate primarily due to lack of familiarity of the English language or the lack of competence?

Dr. **Casterline**. To be registered to take the visa qalifying examination physicians must demonstrate competence in comprehension and use of the English language. I feel the English language is not the problem. The problem with the VQE is the heavy emphasis on basic science—which comprises half of the examination—taken at a time different from that when the U.S. medical students take the same examination material in the national board part I examination.

For example, U.S. medical school students take the basic science subject examinations at approximately the end of the second year of medical school. The individual taking the VQE must be a medical school graduate. They may be 2, 3, 4, 5 years, as many as 10 or 15 years beyond intensive study of the basic sciences.

To perform best in handling basic science material on a basic science examination one must work with it every day. The VQE was declared equivalent to the national board part I and part II examinations and is scored and reported on exactly the same basis as are the national board examinations. The table I described earlier shows that the heavy failure rate is in the basic science segment of the examination.

Mr. **Waxman**. Do FMG's have to take more exams to be licensed in the State here in this country than graduates of American schools?

Dr. **Casterline**. Graduates of American schools perhaps 70 to 75 percent of graduates of medical schools in the United States are licensed by endorsement of their national board certificates. The other 25 percent may have taken national board examinations while in medical school, but may not have chosen to pursue national board certification. Instead, they take the FLEX examination which is the federation licensing examination that is given by the States. Americans who did not seek the national board certification would not only have taken national board type examinations in an American medical school but also would have taken FLEX for licensure.

Graduates of foreign medical schools coming to the United States are required to pass either the ECFMG examination or the visa qualifying examination, and, in addition, take FLEX. The American medical student who chooses the FLEX alternative rather than national board certification takes the same number of examinations as the foreign medical graduate. The physician who chooses national board certification indeed takes a lesser number of examinations.

Mr. **Waxman**. You mentioned the ECFMG exam, the FLEX exam and the VQE exam. Could you again explain those exams and their relationships to one another and to State licensure?

Dr. **Casterline**. Yes. For State licensure, individuals in the United States who graduate from U.S. medical schools may obtain licensure by endorsement of their national board certificates as I mentioned earlier. Others take the federation licensing examination—FLEX—a 3-day examination, which is prepared, by representatives from various State medical licensing boards from the national board bank of calibrated test items.

FLEX is now used in every State, the District of Columbia, several U.S. possessions, and Saskatchewan, Canada. The FLEX questions are drawn from the same pool of test items that supplies national board certification examinations. The visa qualifying examination is drawn from the same pool of test items. In VQE the basic and clinical sciences are given equal weight. In FLEX the basic sciences are given one-sixth of the total score, the clinical sciences two-thirds, and "clinical competence"receives half the score.

The VQE is required in most cases for an alien to obtain a visa to enter the United States, other than physicians who are exempt from that provision. This is required by Public Law 94-484. ECFMG certification which I described in my prepared comments may be obtained by meeting the ECFMG educational requirements. They require completion of the full medical curriculum in an acceptable foreign medical school, and completion of the educational requirements for licensure in the country where the education was obtained. The national of the country involved must obtain the actual license or full registration to practice medicine in the country where the medical education was obtained.

The science examination requirement for ECFMG certification, which is required to enter a graduate medical education program may be met by passing the ECFMG examination, the VQE or FLEX. In all cases to obtain ECFMG certification the individual must pass an English test, to demonstrate that they have competence in comprehension and utilization of the language.

The ECFMG examination has been prepared to determine whether an individual physician has the knowledge to enter a graduate medical education training program in the United States, with full consideration for the safety of the hospitalized patients in this country. Also performance on the examination should allow prediction of ability to learn from the experience in the training program. The ECFMG examination consists of 360 items, one-sixth of which are in the basic science, five-sixths in the clinical science. It has been tailored for the individual entering a clinical situation.

The VQE is half and half. FLEX by volume is one-third, one-third, one-third but weighted one-sixth, two-sixths, and three-sixths.

Mr. **Waxman**. Is this true if they are from France as well as from Britain?

Dr. **Casterline**. Yes.

Mr. **Waxman**. I will have to digest that but you certainly gave me an answer to the question.

Dr. Carter.

Mr. **Carter**. Thank you, Mr. Chairman.

Do you think the VQE test actually serves as a legitimate screening exam to insure entry of qualified foreign doctors?

Dr. **Casterline**. Dr. Carter, I think it depends on what one may be trying to screen. I think if you are attempting to limit the entry of alien physicians I believe it is very successful. I am not convinced that testing an individual in the basic sciences provides great assurance for the safety of hospitalized patients who are being treated by individuals in training programs.

Mr. **Carter**. We are mixing them up a bit there. What portion of the VQE deals with basic sciences?

Dr. **Casterline**. Half of the items come from the basic sciences.

Mr. **Carter**. What part of the test is that?

Dr. **Casterline**. The first day is entirely basic science. That actually consists of one-half of the part I national board examination.

Mr. **Carter**. And the other half?

Dr. **Casterline**. The second day is entirely clinical sciences which is assembled by the National Board of Medical Examiners.

Mr. **Carter**. And you think it is possibly too stringent?

Dr. **Casterline**. I feel that, it depends on the purpose of the examination. If it is to reduce the number of entrants, it certainly has succeeded. If it is to improve the quality of the individual coming in to test his capacity to address the problems of patients in the clinical setting, I am not certain that it has provided much improvement.

Mr. **Carter**. I see. In 1970 I believe we had 8,367 medical graduates. In 1979 we had 15,123. The number has almost doubled. If we have increased the number of physicians by that many, why do we need so many physicians in our metropolitan areas?

Dr. CASTERLINE. I think it is a matter of working conditions. I have visited a hospital in the South Bronx, for example, where there is great difficulty in recruiting American medical school graduates, to residency programs. I must admit that, having visited those areas myself, I would not feel secure in that particular area or in other areas of the several boroughs of New York City where the living conditions are far from satisfactory. The problem is to make the areas safer. Then, I think physicians would go there. However, where there is an opportunity to go elsewhere the physician would go elsewhere.

Mr. CARTER. Some of our people just don't want to go there.

Dr. CASTERLINE. I think it is a matter of choice, that is right.

Mr. CARTER. How does a foreign doctor go about arranging his training with an American hospital?

Dr. CASTERLINE. If he is entered as an exchange visitor, this is ordinarily done prior to his entry. He may visit the United States as a tourist. Many alien physicians who enter the United States as exchange visitors have had, perhaps, a cousin in United States preceding them by several years, or a friend, or a neighbor. The alien physicans have heard that the training program in some place is of good quality and they follow the neighbor and will go to that training institution. They may visit it, may find that the conditions are to their liking, will make preliminary arrangements with the training program director, then they will seek to obtain a contract from institutions to begin a residency.

Once they have obtained a contract for training, if they wish to come to this country as an exchange visitor, they must submit the contract and other necessary documents to ECFMG. ECFMG then issues the document—CIAP-66—that will allow them, to obtain a J-1 visa. Those who come as immigrants or as permanent residents will follow much the same pattern in seeking a position. To a great extent I believe the choice is based on the basis of individual friendships or relationships with those who have been here before them.

Mr. CARTER. Do the hospitals actively seek out foreign doctors?

Dr. CASTERLINE. Some hospitals do recruit, some in areas where they are very short of physicians and particularly where the living conditions are difficult, where the security of the individual is a problem at all times.

Mr. CARTER. As I understand the current law, in order to be eligible for the VQE the candidate must have passed a ECFMG English test within the preceding 2 years, is that correct?

Dr. CASTERLINE. Yes, that is correct.

Mr. CARTER. It has been brought to my attention that the timing of this test does not coincide conveniently with the taking of the VQE and that some native English speaking foreigners—I know one such Australian—have been prevented from taking the VQE because they had not taken the English test in the previous 2 years. Are there any changes you would recommend with regard to the requirement for the English test to address this concern?

Dr. CASTERLINE. Yes; we have done something about that in conjunction with the National Board of Medical Examiners. I know you are familiar with the English language requirement. It resulted from the provisions of Public Law 94-484 which requires demonstration of competence in the use and comprehension of the English language. However, Public Law 94-484 did not stipulate the exact time that it should be given. The National Board of Medical Examiners determined that they would require individuals to have a good understanding of English before they would be allowed to take VQE. This is not only for the protection of their system but for the individual who may be unprepared in English.

The English language requirements in the last year have been modified so that if an individual has never registered for, or never had an application for VQE received at ECFMG, that individual may take an English test immediately before the VQE. The VQE is given every September. The applicant could take the July ECFMG English test. So they may register for VQE if they are registered for the English test.

An individual who has taken a ECFMG English test in the past has the opportunity to take instead of ECFMG a test of English as a foreign language. The test of English as a foreign language is really the queen of English language tests throughout the world. It is one of the most effective in demonstrating competence in the use of English. As a matter of fact, the ECFMG English test is derived from TOEFL. We will accept a specified score on the TOFEL in lieu of passing the ECFMG English test as a prerequisite to the VQE. So there are opportunities for people to work around it. The requirement that you described does remain, but we are offering opportunities for individuals to work this out.

Now the other point that you made is regarding the physician who is an English-speaking Australian. We hear similar comments from the United Kingdom, from South Africa, from New Zealand and elsewhere. The law, as we have interpreted, it does not make any provision for exemption from English language provisions for anyone. Thus, physicians who wish to meet the requirements to enter the United States should meet all of the provisions stipulated in Public Law 94-484.

Mr. **Carter**. Thank you.

Mr. **Waxman**. Why don't you make an exemption for someone whose native language is English?

Dr. **Casterline**. You would be surprised at the number of people who tell us their native tongue is English who fail our examination.

Mr. **Waxman**. What happens if we ask our own better graduates?

Dr. **Casterline**. There are a good many people who feel their native tongue is English, who don't have the level of competence that is stipulated in the law.

Mr. **Waxman**. I was curious to take note of the fact that you give the VQE's in September. It would seem to me that most medical students would be graduated in June.

Dr. **Casterline**. Yes, The Northern Hemisphere.

Mr. **Waxman**. Residency training begins in July. If they take the exams in September, are they doing it before they finish their medical training?

Dr. **Casterline**. No; they cannot take VQE until they have had their final medical school examinations. We will register them for the examinations in the spring. Registration for VQE is concluded early in the summer. The physician who is taking the examination must be a medical school graduate. If he has not passed his final medical school examinations he is not permitted to take the VQE.

Mr. **Waxman**. Are you aware of a significant number of people who are unable to take this exam at one time of the year in which it is given because of conflicting obligations?

Dr. **Casterline**. Yes, this has come up.

Another point that I wanted to include in my earlier comments is that the date of the VQE is set so that it coincides with the National Board of Medical Examiners part I examination. When the national board and ECFMG volunteered to provide an examination to meet the purposes of the law, it was with the understanding that the examination was to be considered equivalent—for the purposes of the law—to the national board part I and part II examinations. So, to be as equivalent as possible, the examination is given the same day that American and Canadian medical students take the national board part I examination in the United States and Canada. It is taken on the same day, scored at the same time, so that the equivalence is really as close as possible. This was determined by the national board as another way to assure the equivalence which is required by the law.

Mr. **Waxman**. I have heard complaints from people that since it is given only one time a year and many have to travel long distances to take the examination that they consider it unfair. I would be interested in your reaction to it in weighing that against the idea of making the equivalency also at the moment in time the exams are taken in the United States. I don't really see how that makes an exam equivalent.

Dr. **Casterline**. In answer to your prior question, the psychometric people do evaluate the examinations all at the same time, so that the questions and responses are evaluated at the same time. The scoring is done at the same time for the alien physicians taking the VQE and the United States or Canadian students taking the part I national board examination.

The number of centers has been limited to security. ECFMG has had more than 20 years of experience in administering examinations throughout the world. We have had up to 165 centers. We operate about 145 centers for the ECFMG examination. We are aware of areas in which security is difficult to maintain and those in which it is easy to maintain. We chose, initially, at the request of the national board, approximately 30 centers which are the most secure. The reason for the intense security is that in VQE we are administering national board certification material that is used for licensure in the United States.

One of the problems that we are dealing with, is the need for absolute security for the examination materials. So, we utilize a trained staff of proctors that have had experience over many years, and use facilities that we know are secure.

Mr. **Waxman**. Thank you very much.

Mr. Maguire.

Mr. **Maguire**. I have no questions, Mr. Chairman.

Mr. **Carter**. Mr. Chairman, I have one question.

How many graduates of the University of Caribbean have you had take the VQE?

Dr. **Casterline**. American University of Caribbean taken the VQE?

Mr. **Carter**. Yes.

Dr. **Casterline**. To my knowledge, none. They are primarily Americans and they are required to take the ECFMG examination.

Mr. **Carter**. Yes, sir. Do you have many foreign medical graduates come through Canada as Canadians and then come on into the United States?

Dr. **Casterline**. The requirement is that any physician coming from Canada must have graduated from an accredited school, which means that the individual must be a graduate of the Canadian school to be exempt from VQE. Coming in through Canada does not provide exemption from VQE. They must be graduates of Canadian medical schools.

Mr. **Waxman**. Dr. Casterline, we appreciate your testimony and your being with us today.

We are going to recess to respond to a vote on the House floor.

[Brief recess.]

Mr. **Waxman**. We will now hear from our panel on geographic distribution of physicians. The members of our panel are Dr. Karen Davis, the Deputy Assistant Secretary of HEW; Dr. Don Dewey, associate professor, department of geography at DePaul University, and Mr. Jack Cornman, the president of the National Rural Center. Accompanying Mr. Cornman is Dr. Donald Madison of the University of North Carolina.

We are pleased that you can all be with us today. Your prepared statements will be made part of the record. Dr. Davis, if you can summarize your statement for us we will appreciate it. So we can have an opportunity to get to questions and answers, we would like to have you keep close to 5 minutes.

STATEMENTS OF KAREN DAVIS, PH. D., DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION/HEALTH, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; JOHN M. CORNMAN, PRESIDENT, NATIONAL RURAL CENTER, ACCOMPANIED BY DONALD MADISON, M.D., UNIVERSITY OF NORTH CAROLINA; AND DONALD R. DEWEY, PH. D., PROFESSOR OF URBAN GEOGRAPHY, DE PAUL UNIVERSITY (CHICAGO)

Dr. **Davis**. Thank you. I am pleased to be here today to discuss the geographic distribution of health professionals. This subcommittee has shown strong leadership in developing strategies to meet the Nation's health personnel needs. This hearing provides a special opportunity to focus on the requirements of underserved areas.

Dr. Richmond discussed the administration's Health Professions Education Amendments of 1980 in his testimony before you last week. As he indicated, this legislation is targeted to provide support for training the types and numbers of professionals necessary to meet the Nation's most pressing health service needs. One of the most serious concerns addressed by this proposal is the maldistribution of health professionals.

During the 1960's, the Federal Government concentrated heavily on helping to increase the supply of health professionals. Programs like capitation grants, construction and startup assistance have had a definite impact on increasing the aggregate supply of health professionals.

The supply of active physicians increased from 251,900 in 1960 to 447,800 in 1980: the physician/population ratio jumped from 136 physicians per 100,000 population to 202 physicians per 100,000 people during this period. In fact, our best estimates indicate that the projected supply of most health professionals, especially physicians, is expected to exceed need by 1990.

Yet despite recent gains in overall supply, many areas—largely inner city and rural communities—still lack adequate health personnel. The maldistribution of health professionals, especially physicians, remains our most pressing concern.

We estimate that in 1990, up to 16,400 additional physicians and midlevel professionals could be needed in medically underserved areas and facilities: 7,500 in rural areas; 5,200 in inner cities; and 3,700 in prisons and mental institutions. These estimates assume that the number of physicians choosing to locate in rural areas increases because more are entering practice in the aggregate.

Fortunately, there is evidence of some increase in the number of physicians moving into smaller cities and towns over the past 5 to 7 years. However, most of the increase in physician/population ratios has occurred in medium sized rural towns. Few of these physicians have chosen to locate in underserved areas—largely poor or highly rural communities with few health resources—designated as high priority by the Federal Government.

Between 1971 and 1977, the patient care physician/population ratio increased from 48 patient care physicians per 100,000 to 50 patient care physicians per 100,000 in highly rural areas. This compares with an increase in the ratio from 72 patient care physicians per 100,000 to 87 per 100,000 population in other rural areas and an increase in the ratio from 146 patient care physicians per 100,000 to 168 in metropolitan areas.

In high poverty areas, the physician/population ratio increased from 68 patient care physicians per 100,000 population to 74 patient care physicians per 100,000 population.

In poor rural and urban counties, the problem is exacerbated because many physicians chose not to accept medicaid patients; 22 percent of primary care physicians have no medicaid patients.

There is also some expectation that the proportion, as well as the numbers, of physicians going to underserved areas will increase as the supply of doctors grows. Almost 16,000 new graduate physicians are added to the pool each year.

However, aggregate physician to population ratios have increased nearly twice as fast in the 1970's—2.7 percent annually—as in the 1960's—1.5 percent annually—and, as I have indicated, highly rural and poor areas have shown very small increases to date.

Although very rural and poor counties have not benefited from the increased diffusion of physicians as yet, we plan to monitor carefully future patterns as the supply of doctors grows. We intend to study the location trends that emerge over the next few years and reappraise our strategies for meeting the needs of underserved areas based on this experience.

It is important to remember that increased supply of health professionals and improved financing of health care services cannot alone attract providers to underserved rural and inner city areas. While we find this prospect hopeful, we know that the multiple problems found in these areas—professional isolation, the lack of cultural and educational opportunities—are likely to affect location choices as much as potential income.

As I noted earlier, Mr. Chairman, our proposal targets Federal support for health professions training on programs to address geographic maldistribution. To help assure that health professionals are available in underserved areas, the administration proposes to continue the National Health Service Corps. We plan to maintain the proposed 1981 scholarship levels which will lead to an expansion in NHSC field strength. This will result in the placement of a total of roughly 9,000 assignees including physicians, nurse practitioners, physicians assistants, dentists, registered nurses, and others by 1990. These plans assume 6,700 service committed practitioners and the 1981 level of 2,300 volunteers.

Some States have supported their own student assistance programs to improve the distribution of health professionals. We favor authorizing the Secretary to enter into cooperative agreements with those States to provide for closer accord in the placement of corps personnel in Federally designated shortage areas. Such joint Federal-State demonstrations should increase State input in health planning and management, minimize unwarranted duplication of effort, and target all programs toward improving the supply of health professionals in shortage areas.

Another key program for meeting the needs of health manpower shortage areas is the Area Health Education Center—AHEC—program. This program provides for the enhancement of health professions training opportunities in areas remote from existing education centers. The 21 AHEC programs receiving Federal support in fiscal year 1979 were operating or developing 30 regional centers serving over 433 counties in 22 States.

There are many other areas, Mr. Chairman.

In summary, Mr. Chairman, we recognize that assuring access to basic health care services for Americans living in underserved rural and inner city areas is a significant challenge. The administration's health professions proposal addresses this issue by providing support for programs designed to improve the geographic distribution of health personnel. Through such efforts as the National Health Service Corps, the Department can provide leadership and assume responsibility for helping to improve access to needed health services for all Americans.

Thank you.

Mr. **WAXMAN**. Thank you very much.

Mr. Cornman.

STATEMENT OF JOHN M. CORNMAN

Mr. **CORNMAN**. Thank you, Mr. Chairman. My name is Jack Cornman, and I am president of the National Rural Center. If I may, I would like to just highlight maybe four points in my testimony and comment a little bit on each of those. [See p. 591.]

As you consider the needs of rural areas, you have to keep in mind one very important point: rural America is diverse which makes it very difficult for researchers to capture rural realities in a broad quantitative study and for policymakers to come up with definitive programs.

Two, in too many, but not all, rural areas, rural people have limited access to health providers, and figures show that rural residents are sicker than metropolitan residents.

Three, despite the increased numbers of individuals being trained as doctors, the lack of health providers in many rural areas remains a principal barrier to easing the access problem.

And four, efforts to increase access to health care if they are to be successful cannot be considered in isolation but must be linked with other health policy questions and indeed other developmental issues. Also they must be approached with the understanding that development efforts, whether talking about health or otherwise, take time to reach their goals.

In discussing these points it might be helpful for you to know the general viewpoint, bias, if you will, from which I speak. In brief, I believe the Nation has an important stake in the well-being of rural America—a stake that stretches from meeting society's responsibilities to the poor to obtaining such national goals as full employment, adequate housing and containing medical costs to providing individuals with real options for decent lives in the communities of their choice, a freedom basic to the well-being of the democratic society.

My comments on health and the health programs should be measured against those concerns.

As far as rural diversity, rural areas differ by size, geography, racial makeup, affluence, poverty, rate of growth and decline, economic base, stage of development and population density.

Despite the much discussed or publicized migration turnaround, rural areas are home to a disproportionate number of the Nation's poor. While the rural poor comprise 34 percent of the Nation's poor population, rural areas contain only 27 percent of the total population. And because of the migration, while many nonmetropolitan or rural and small towns have experienced some growth in the 1970's, at least 600 rural counties have continued to decline in population during that same period.

The need for additional health services in rural areas is indicated by the fact that rural people tend to be sicker, if that is the right word. A few statistics illustrate the point. Infant mortality rates are as high as 70 percent above the national average in some rural areas. Chronic conditions afflict rural people more frequently and more severely than urban residents. The rural population generally is older than the national average. Respiratory illness among adults and accidents related to the hazardous occupations of mining and farming are particularly serious problems in many rural areas. I think it is also significant to note that a nonmetropolitan resident is less likely to never have received such preventive services of electrocardiograms, glaucoma tests and so forth as compared to what is available to metropolitan residents.

Very briefly, on the maldistribution of physicians in rural areas, according to a 1978 HEW report, the ratio of doctors to population in metropolitan counties was nearly twice as large as that in nonmetropolitan counties. Furthermore, according to a report, a disparity, although somewhat smaller, also exists for primary care doctors for which the ratio in metropolitan areas was 46 percent higher than the ratio in nonmetropolitan areas. Data analyzed by our center further show the States with the lowest physician/population ratio are States with the highest percentage of nonmetropolitan residents and States with large numbers of non-metropolitan poor people.

To bring the national statistics down to a more local level, let me just note, the State of Kentucky. During 1960 to 1967, 43 of the 103 nonmetropolitan counties had a net loss in the number of physicians and 54 of the 103 counties had a reduction in physician/population ratio. This next figure makes it important to understand the diversity of rural areas because in the metropolitan areas of that State during the same period, 7 out of 17 metropolitan counties had a reduced physician/population ratio, and all of these counties were rural even though they are classified metropolitan because they are within a commuting distance.

Mr. Carter. Mr. Chairman, may I ask the gentleman where he is from.

Mr. Cornman. From the National Rural Center.

Mr. Carter. No, I mean what State?

Mr. Cornman. I live in Arlington, Va.

Mr. Carter. Where were you born?

Mr. Cornman. I was born in Philadelphia.

Mr. Carter. So you're from a metropolitan area.

Mr. Cornman. I am. Could I ask why you asked?

Mr. Carter. Because I believe it's very difficult to understand the problems of rural areas unless you have grown up in one, and frankly I disagree with what you've stated.

Mr. Cornman. The figures aren't correct?

Mr. Carter. No, I don't believe they are.

Mr. Cornman. Well, we received them from HEW.

Mr. Carter. It does not matter where you got them.

Mr. Waxman. Why don't you complete your testimony and we will go into the evaluation of the testimony. With the questions we can clarify points that might be in dispute.

Mr. Cornman. Certainly. Basically, let me summarize by saying when you consider the questions of the maldistribution and solving the questions of maldistribution of physicians in rural areas, you do need to think of the other kinds of policy issues and conditions which affect those and why doctors do choose to go where they go. Thank you.

[Testimony resumes on p. 605.]

[Mr. Cornman's prepared statement follows:]

STATEMENT OF JOHN M. CORNMAN, PRESIDENT, NATIONAL RURAL CENTER

Mr. Chairman and Members of the Subcommittee:

Mr. Chairman, thank you for the invitation to testify about the availability of health care in rural areas. Let me begin by introducing myself and my organization. I am Jack Cornman, president of the National Rural Center. The center is a private, non-profit, non-membership organization created to provide information which can help rural people improve the quality of life in their communities. Our definition of information runs from providing a limited form of technical assistance to the development of policy alternatives through research, program evaluation, demonstration projects and the monitoring of the preparation of laws and regulations at the federal level. Our working premise is that people ought to have a chance for a decent life in the kind of community in which they want to live, and that the goal of government ought to be to increase rather than limit that option.

Access to adequate health care is important to improving the quality of life for many rural people. One barrier to assuring such access is lack of health providers in many rural communities, a shortage which exists despite the increased numbers of persons being educated and trained to become physicians. Efforts to correct maldistribution of medical personnel are complicated by complexity of the causes and, at least from the viewpoint of the policymaker, the diversity of rural America which defies macro solutions. Therefore, to try to put the problem of maldistribution of physicians in a rural context, particularly at this time of reductions in federal spending, I would like to give some idea of the diversity which exists in rural America, some measures of health status which indicates the importance of the issue to rural people, and some data on the distribution of health practitioners in rural areas. Following that I will offer some suggestions for adjusting the National Health Service Corps and other health person power programs to better meet rural needs.

Rural areas differ by size, geography, ethnicity, affluence, poverty, rate of growth or decline, economic base, stage of development, and population. Rural is a ski resort in New Hampshire, a boom town near a revitalized coal mine in Appalachia; a deserted town near a played out mine; the Black belt of the Southeast with high rates of poverty, illness and unemployment; large farms; small farms, some successful, some marginal; "colonials" in the Southwest, which consist of tar paper shacks for homes for Mexican-Americans; energy resources; exploited land; water and solar power; cold winters and high fuel prices; communities attracting population and communities losing population; new potentials and old problems.

As one who has given this speech on more than one occasion, I find that many people have a misperception about the quality of life in rural areas, particularly in light of the much publicized reversed migration.

Despite that turn-around, disproportionate share of the nation's poor are located in rural or nonmetropolitan areas. The rural poor comprise 34 percent of the nation's poor population but only 27 percent of the total population live in rural areas. The rural poor are disproportionately located in certain regions of the country, namely the South and the Southwest. For example, some counties in the Pacific Northwest and the cornbelts of the Midwest have poverty rates of only eight percent and 11 percent respectively compared to some counties in the South and the Southwest with poverty rates of 35 percent and 42 percent.

While many nonmetropolitan or rural and small town areas have experienced wide spread and substantial population growth in the 1970's, some 600 rural counties have continued to decline in population during that same time period.

These variations in rural areas mean that health and other programs must be flexible to meet different conditions.

The need for additional rural health services is indicated by the fact that rural people tend to be sicker than urban residents. A few statistics illustrate the point:

- o Infant mortality rates are as high as 70 percent above the national average in some rural areas.
- o Age-adjusted death rates are higher in nonmetropolitan

areas and have been declining at a slower rate in rural areas than in urban areas.

- Chronic conditions afflict rural people more frequently and more severely than urban residents.
- The rural population generally is older than the national average.
- Respiratory illness among adults and accidents related to the hazardous occupations of mining and farming are particularly serious problems in rural areas.
- Death rates from accidents are four times higher in rural areas than in urban areas.
- Dental problems are serious among rural residents. Loss of permanent teeth is common among young adults in some rural areas.
- The life expectancy of migrant workers is 49 years compared to 74 for the remainder of the population.

The high morbidity and mortality rates can be partly attributed to the high poverty rates in rural areas. The effects of environment and life style on health status are also well known. The environmental hazards and life style of poverty -- inadequate housing, impure water, unsanitary toilet facilities, poor diets, et cetera -- result in numerous, often preventable diseases. Significant is also the fact that a nonmetropolitan resident is less likely to never have received such preventive services as electrocardigram, glaucoma test, chest X-ray, or pap smear than a metropolitan resident outside the central city. In addition, rural people are hospitalized more often for non-surgical reasons than metropolitan residents. For example, hospitalization occurs 27 percent more frequently among nonmetropolitan residents than non-central city metropolitan people, and 35 percent more frequently in the nonmetropolitan South.

The data on physician distribution point to a persistent problem in many rural communities. The distribution of health practitioners is generally described by comparing the supply of health practitioners relative to population in specified geographic areas. Generally these data compare nonmetropolitan areas with metropolitan areas, equating "nonmetropolitan" (any place outside a standard metropolitan statistical area) with "rural". These statistics continue to show a wide disparity in the physician/population ratio between metropolitan and nonmetropolitan areas. For example, according to the 1978 HEW Report to Congress on the Status of Health Professions Personnel, the ratio of M.D.s to population in metropolitan counties was nearly twice as large as that in nonmetropolitan counties. Furthermore, according to the report a disparity -- although somewhat smaller -- also exists for primary care M.D.s for which the ratio in metropolitan areas was 46 percent higher than the ratio in nonmetropolitan areas.

In addition, in looking at increases in physician/population ratios between 1972 and 1976 the data show that many rural counties with small to medium size rural towns, had much smaller increases in the physician/population ratios than did metropolitan counties. The increases in these physician/population ratios ranged from 12 percent in metropolitan counties to about eight percent in nonmetropolitan counties with small to medium size rural towns to zero percent in some thinly populated rural areas. In other words, many rural communities are getting further and further behind metropolitan communities in attracting and retaining physicians.

Data analyzed by the National Rural Center further show that the states with the lowest physician/population ratios are states with the highest percentage of nonmetropolitan residents and states with large numbers of nonmetropolitan poor. In 1968, 24 of the 27 states with the highest percentage of nonmetropolitan residents in 1976, ranked the lowest in primary care physicians per 100,000 population. In 1977, many of these states continued to show the lowest physician population ratios. These 24 states also accounted for about 55 percent of the nonmetropolitan poor in 1975.

To bring the national statistics down to a more local level and to illustrate the physician shortage problem in states which represent diverse rural conditions I would like to present data for the states of Alabama, Kentucky, North Dakota, and New Mexico.

Alabama

- Alabama is a southern, rural state with large numbers of rural poor and a large rural minority population.
- The number of physicians in the state between 1960 and 1977 increased by 1,764 providers, most of whom located in the metropolitan areas of the state.
- During 1960-1977, 23 of the 49 nonmetropolitan counties in the state had a net loss in the number of physicians and 24 rural counties had a reduction in the physician/population ratio.
- In metropolitan areas of the state during the same time period six of the 18 metropolitan counties had a reduction in physician/population ratio -- all of these counties are rural counties but classified as metropolitan only because

of the commuting patterns to the major metropolitan county.

Kentucky

- Kentucky is a mountainous state with large numbers of rural poor.
- The number of physicians in the state between 1960 and 1977 increased by 1,714 providers most of whom located in the metropolitan areas of the state.
- During 1960-1977, 43 of the 103 nonmetropolitan counties had a net loss in the number of physicians and 54 of the 103 counties had a reduction in the physician/population ratio.
- In metropolitan areas of the state during the same time period seven of the 17 metropolitan counties had a reduced physician/population ratio -- all of these counties are in fact "rural" but classified as metropolitan.

North Dakota

- North Dakota is a rural, wide open, plains state with relatively few nonmetropolitan poor residents.
- The number of physicians in the state between 1960 and 1977 increased by 263.
- The state has only two metropolitan counties both of which had an increase in the number of physicians and in the physician/population ratio between 1960 and 1977.
- During 1960-1977, 37 of the state's 51 nonmetropolitan counties either experienced a net loss in the number of physicians or had no change in the number of providers.

During the same time period 20 of the nonmetropolitan counties experienced a decrease in the physician/population ratio.

- In 1960, six nonmetropolitan counties had no physicians, by 1977 this number had almost doubled (11).

New Mexico

- New Mexico is a southwestern rural state with large Mexican-American rural population.
- The number of physicians in the state between 1960 and 1977 increased by 934 providers.
- The state has only two metropolitan counties, both of which experienced an increase in both the number of physicians and the physician/population ratio.
- Between 1960 and 1977, six out of the 30 nonmetropolitan counties had a decrease in the number of physicians and ten nonmetropolitan counties had a decrease in the physician/population ratio.

To further illustrate the problem of physician shortage in small rural communities I would like to refer to a study recently completed by Madison and Combs on "Location Patterns of Recent Physician Settlers in Rural America." The study focused on 951 physicians aged 45 and younger settling in towns with less than 10,000 population in counties with less than 50,000 people between 1973 and 1976. The physicians studied were those who stayed in these locations for at least one year, and were still there in August 1977.

The results of the study showed that these physicians tended to go to the communities where there already was a medical community.

They did not generally choose to begin practice as the only physician, nor did they choose to go places with only one, two or three other physicians -- two-thirds of the physicians chose to locate in towns where four or more physicians were in practice already. Only 63 physicians chose to locate in a town as the only provider. An important attraction for these young physicians who moved to small towns during 1973-1976 was an already existing medical community of at least four others. The study seems to indicate that it will be difficult for rural communities losing their physicians to recruit young providers without assistance from a program like the National Health Service Corps. This conclusion is supported by the results of a study done for the National Rural Center.

The study examined 11 private and grant-supported rural practices -- nine of which had full-time physicians on site. The research found that all the practices, whether or not they are presently receiving grant support, had started with some kind of outside assistance, such as the National Health Service Corp, a foundation grant or community funding. The study further showed that the self-sufficient private practices were receiving substantial revenues from a hospital practice without which they also would have had to rely on outside support to meet the practice expenses. It may be difficult, if not impossible, under the current reimbursement system for practices in isolated rural areas without access to a hospital or a sizable hospital practice to ever become financially self-sufficient. A need to provide permanent funding for such practices from outside sources to meet expenses, may be necessary. Of course, these conditions are exacerbated in poor rural communities.

Clearly then an increase in the national supply of physicians alone does not significantly increase the number of physicians choosing to practice in many rural areas. A number of studies have attempted to identify the factors which do influence physicians to their choice of practice locations. While the results of each study point to a broad range of factors, several factors appear consistently:

- background of the physician (i.e. residence in high school);
- opportunities for partnership or group practice;
- place of medical training;
- availability of clinical support personnel;
- opportunities for continuing medical education and consultation;
- preference for urban or rural living;

Given the data on the geographic distribution of physicians and the findings of factors influencing their practice location, it seems appropriate to re-evaluate current strategies for meeting the health manpower needs of rural areas.

Some of the key issues that need to be considered in designing health person power programs and policies for rural medically underserved areas are:

1. The kinds of providers to be trained to alleviate the problem of rural underserved areas.

To deal with the shortage of health professionals, many rural communities, especially small isolated rural towns, have established practices staffed by nurse practitioners and physician assistants with back-up support provided by near-by doctors. This model has worked well in many rural communities. And, even with the increase in number of physicians it is unlikely that very small communities can attract or support a full-time physician. Thus the continuing role of nurse practitioners and physician assistants as alternatives to physician practice must be considered. This has implications for federal funding for the training of nurse practitioners and physician assistants as well as for the availability of NHSC and other student assistance for the training of these providers.

2. Background and selection of medical students, especially National Health Service Corps scholarship recipients.

Given the research finding that medical students from rural backgrounds are more likely to return to rural practice, efforts to recruit rural students should be encouraged. A student's geographic background should be especially important in choosing NHSC scholarship recipients, as these students eventually must serve in underserved areas, many of which are rural. It is critical that those NHSC scholarship applicants most likely to remain in underserved areas are awarded scholarships.

In addition, the NHSC should improve its orientation to students entering medical schools in order to make the NHSC scholarship recipient fully aware of the implications of accepting a NHSC scholarship. A student entering a medical school who understands the implications of accepting NHSC scholarship is better prepared to fullfill his/her commitment in a health manpower shortage area. Because of the increasing costs of medical education and limited sources of financial assistance for medical students, it is likely that students with no interest or desire to practice in an underserved area will apply for a NHSC scholarship for simple financial reasons. Thus it is critical that only those NHSC scholarship applicants most likely to remain in underserved areas will be awarded scholarships.

3. Training of Health Professionals

Physician training involves a long education process. What happens to students during their socialization into the medical profession will influence the student's preference for practice location. The process and content of medical education itself may discourage students from choosing a rural practice. Medical education centers are usually located near large urban teaching hospitals whose resources, case mix, and role models are far removed from the realities of rural practice. Many physicians complain that they are poorly prepared to deal with the primary care needs of their patients after being trained in settings where patients have more complicated problems and where diagnosis and treatment rely on high technology not available outside teaching facilities. Family practice, rural preceptorships and residency training experiences will increase the number of physicians choosing a rural practice.

The medical education process is especially critical for NHSC scholarship recipients. The training of the scholarship students should focus on primary care specialties and educational experiences which will best prepare physicians and other health professionals for a practice in an underserved area. Cooperation and coordination between academic medical centers and the NHSC is essential for the success of the NHSC program.

4. Establishing Practices in Underserved Rural Areas.

The federal government has undertaken several initiatives to increase the access to health services in medically underserved areas of the United States, including the Community Health Centers program, Rural and Urban Health Initiatives, the Migrant Health Centers program, and the National Health Service Corps. Most of the health centers established under these initiatives are still relatively young, but some lessons can be drawn from the experience thus far.

First, it is extremely important to provide technical assistance for the community from the start of the planning process for a health center. This assistance should include assistance in the selection of the site for the health center, the selection of the governing board, and recruitment and retention of providers, and continued assistance in the financial management of the center.

Second, placing providers in medically underserved areas does not mean that, because a shortage of providers exists in a community the new practice will automatically and immediately generate enough practice revenues to meet expenses. Practice build-up takes time in sparsely populated rural areas. Prior to the establishment of the new practice, residents of the community probably have obtained other sources of medical care outside the community's service area, many times at a great distance. It takes time to break old habits and for residents to change providers, many of whom may be skeptical about the continued presence of the new provider. The study recently completed for the National Rural Center identified some factors which contributed to ease in practice development. For example, taking over a practice of retiring physician or locating in a community shortly after a retirement apparently makes it easier for a new provider to attract patients in the early years of the practice.

Third, the center study also found that the private practices studied received a substantial part of their revenues from a hospital practice without which these practices would have been unable to meet practice expenses. In rural areas without hospitals in those areas or practices with some or no hospitalization, it may be impossible under the current reimbursement system for practices to become financially self-sufficient. In addition, many serivces provided by federally funded centers such as health education, transportation and outreach are not reimbursable services under the current reimbursement system and thus must be supported by other funding sources.

Fourth, programs must be flexible enough to meet the needs of various rural communities. The programs needed in the Blackbelt of the Southeast are very different from those in the cornbelt of Iowa or mountains of the Pacific Northwest.

Mr. **Waxman**. Thank you.
Dr. Dewey.

STATEMENT OF DONALD R. DEWEY, PH. D

Dr. **Dewey**. I will move from my prepared statement and just try and very briefly summarize for you the things that I have.

Mr. **Waxman**. Your prepared material will be made part of the record.

Dr. **Dewey**. I have been studying physician manpower in metropolitan Chicago for the past 10 years. I examined the geographic distribution of total physicians and various subsets of physicians during that time. I have looked at the distribution of physicians by type of practice, specifically the office-based and hospital-based practitioners in Chicago. I have examined the distribution of physicians by the age of the doctor, by the medical specialization patterns. I have compared the distribution of foreign medical graduates and U.S. medical graduates in Chicago, in the metropolitan area. I have examined foreign medical graduates by type of the distribution of foreign medical graduates, by type of practice, age, specialty and the countries of medical education.

The geographic distribution of each of these groups has been examined at four levels of geographic detail within the metropolitan Chicago area. Their geographic distribution has also been compared with the geographic distribution of six socioeconomic and demographic factors; namely, the total population, black population, low income population, affluent population, retail shopping centers and hospital facilities.

Several distinctive, reoccurring patterns emerged from each of these studies. The total number of physicians is increasing faster than the population; that is, the physician population ratio is rising for total physicians. However, the number of physicians providing primary care has been decreasing causing the office-based and hospital-based physician to decrease. They have fallen significantly.

All physicians regardless of type of practice, age, medical specialty, and these other categories are shifting away from areas with high concentrations of blacks and poor population and they are attracted to areas with concentrations of affluent population. This is more true for younger doctors than for older doctors, it is more true for specialists than for general practitioners, it is more true for foreign medical graduates than for U.S. medical graduates, it is more true for foreign medical graduates from Third World nations than for foreign medical graduates from developed nations, it is far truer for younger foreign medical graduates than older foreign medical graduates, and for foreign medical graduate specialists.

I have found, for example, that the average age of doctors in the 10 poorest neighborhoods in Chicago and the 10 neighborhoods with the highest percentage of black population was about 14 years older than the average age of doctors in the 10 wealthiest communities; that is, in the poorest areas the average age was 62 years old, in the wealthiest areas it was 48 years.

I have found that the physician/population ratio in affluent areas was nearly 10 times that of the physician/population ratio in poor and black areas. The physician/population ratio in wealthy areas was 230 doctors per 100,000 and in the poor neighborhoods 26 per 100,000 population. That is 1 doctor for 322 people in rich areas compared to 1 doctor for 3,030 in poor neighborhoods. The trends were consistent and have been consistently toward widening the gap between doctor rich areas and doctor poor areas.

In summarizing my findings I note that part of the difficulty of solving the problem of access to physicians in metropolitan regions is that it is identified simply as a maldistribution of physicians when the problem is a shortage of primary care physicians. As long as the increase in total number of doctors is focused on and is interpreted as trending toward an oversupply of doctors, while there is a decrease in primary care physicians and that is ignored, I do not think they will solve the problem.

As long as the demands for primary care physicians in doctor rich areas is great enough to absorb the limited amount of primary care, physicians in needy areas will be unable to attract adequate numbers of primary care physicians. This suggests three possible solutions to the problem: Increasing the supply of primary care physicians, encouraging physicians to provide some form of itinerant service in medically underserved areas or regulating the distribution of primary care physicians within metropolitan regions. Increasing the supply is more in keeping with the principles of the free market.

My recommendations contain specific actions which can help alleviate the shortage of primary care physicians by shifting the emphasis in medical education from specialization in highly technical specialties to primary practice and other suggestions for encouraging a more equitable distribution of physicians throughout the metropolitan area. The suggestions include methods for both voluntary, that is incentives, and regulated redistribution of physicians in large cities. I much prefer the incentive methods but if they fail I see a need for regulating the geographic distribution of physicians in large cities.

If incentives and the shifting emphasis in medical education do not succeed in increasing the supply of primary care physicians for medically underserved areas and the physician cannot be encouraged to serve at least part time in the inner-city clinics, regulations of distribution of these physicians might become necessary. And as undesirable as forced distribution may be, it has helped to improve education, inadequate housing and make adequate housing more accessible to all. Health care is no less important a right than schooling or housing.

Thank you.

[Testimony resumes on p. 621.]

[Dr. Dewey's prepared statement and attachment follow:]

A BRIEF SURVEY OF PHYSICIAN MANPOWER SHORTAGES IN METROPOLITAN CHICAGO, 1950-1974

by

Dr. Donald R. Dewey

Professor of Urban Geography

De Paul University

The studies summarized in this report provide evidence of continuing maldistribution of physicians in metropolitan Chicago. The trends identified in Chicago, with few exceptions, typify those occuring in most large cities of the U.S.

Six factors are identified as significant factors contributing to the maldistribution, or local area shortages: (1) the decline in percentage of M.D.'s entering office-based primary practice, (2) the proportion of Black population in a community, (3) variation in the socio-economic status of an area, (4) the physician's age, (5) the increasing proportion of specialists, (6) the suburban flight of doctors (decentralization).

An early study examining the changing geographic distribution of physicians in Chicago between 1950 and 1970 indicated six socio-economic and demographic factors (SED)factors; black population, poverty population, total population, affluent population, retail shopping centers, and hospital facilities; significantly influenced the distribution of physicians in the Chicago Standard Metropolitan Statistical Area (SMSA).[1] Between 1950 and 1970 doctors fled areas with, or changing toward, high concentrations of the first two factors (black and poor populations), while they were attracted to areas with concentrations of the last three factors (affluent population, retail shopping centers, and hospital facilities). For example, the physician/population ratios of the ten most affluent communities in the Chicago SMSA rose from 1.78/1000 in 1950 to 2.10/1000 in 1970. The same ratio for the ten most impoverished communities fell from .96/1000 to .26/1000. This means the disparity between the population one doctor served in rich or poor areas rose dramatically in the 20 year study period. In 1950 doctors in poor neighborhoods served twice the population doctors in rich communities served but by 1970 doctors in poor areas served eight times the people their counterparts in wealthy areas served.

A later study analyzed the effects of the physician's age as a locational factor.[2] The study showed that younger doctors chose locations in the wealthier suburbs leaving the poor and black neighborhoods of the city to older physicians. The study declared that the average age of physicians in the ten poorest urban neighborhood rose from 57.8 to 62.4 between 1950 and 1970, while the average age of physicians in the ten wealthiest communities remained at 48.3 throughout the study period. In 1970 only 16% of the physicians in the poor neighborhoods were under

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[1] Donald Dewey, Where the Doctors have Gone Illinois Regional Medical Program, Chicago Regional Hospital Study, Chicago, 1975.

[2] Donald Dewey, "A Survey and Analysis of the changing Age Distribution of Private Practice Physicians in Metropolitan Chicago, 1950-1970." Paper presented to the 20th Annual meeting of the Association of American Geographers, Seattle, Washington, 1974.

46 years old while almost 30% were 65 years or older. In the same year nearly 40% of the physicians in the wealthiest communities were under 46 years, while only 10% were 65 years or older. So, the most impoverished populations (probably those with the greatest health problems) have not only the fewest doctors, but the oldest ones as well. The dire consequences of this are clear. Large percentages of doctors serving the poor will soon reach retirement age with few young doctors to replace them. This can only mean further declines in the already dangerously low physician population ratio in these areas with great medical needs.

The massive importation of foreign medical graduates (FMGs) in the sixies and seventies was seen as the panacea to the problem of doctor shortages in inner city areas. A recent study of the impact of FMGs in relieving the maldistribution of physicians revealed that practice patterns and location of FMGs is not very different from that of USMGs.[3] Medical and specialty practice patterns, age specific distributions and geographic distribution of FMGs do little to alleviate the shortage of doctors in medically underserved areas.

Data from this last study helped to update the trends cited in the earlier studies to 1974. Analysis of the growth, types of practice, age, (specialty office-based) and geographic distribution of office-based USMGs and total physicians revealed that the trends of the fifties and sixies were continuing in the seventies. For example, the total number of USMGs in the Chicago SMSA rose from 8471 in 1970 to 8683 in 1974 but number of office-based USMGs fell from 4786 to 4391 during the same four years. Thus, while the total number of physicians was increasing steadily the number of private practitioners continued to decrease making fewer physicians available for primary care. The increase in total physicians matched the growth in population. The total physician/population ratio remained 1.23/1000 between 1970 and 1974 but the office-based physician population ratio declined from .70/1000 to .62/1000 in the same four years.

Of greater importance than the type of medical practice physicians enter is the question of whether those who do provide primary care are shifting into medically underserved areas.

To understand the significance of the changing distribution of physicians in Chicago, it is first necessary to clarify the growth and geographic distribution of the six SED factors. The changing distributional patterns of these factors are clearly depicted in maps 1-6.

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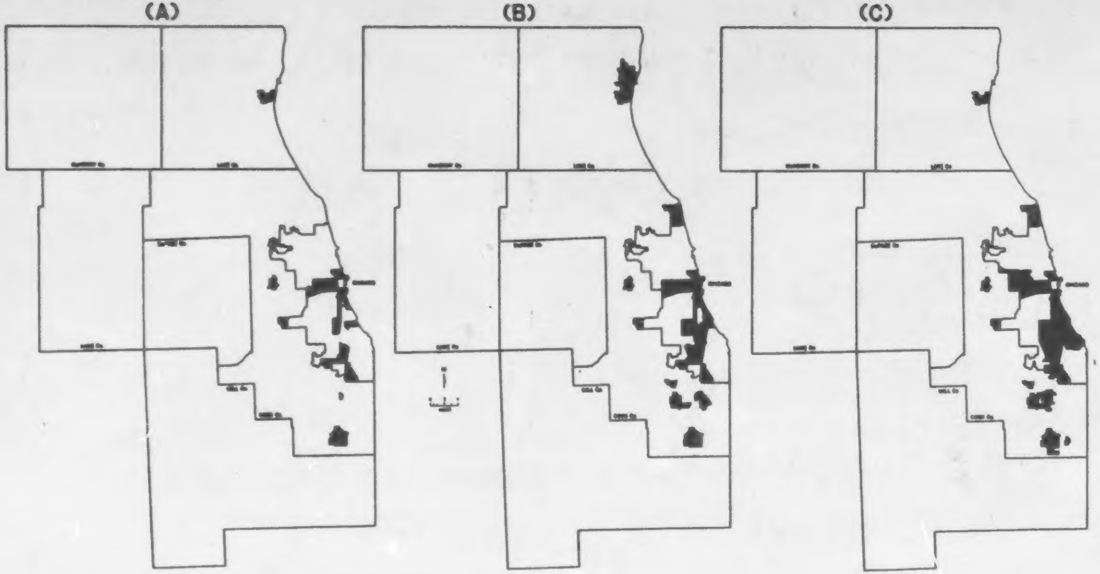
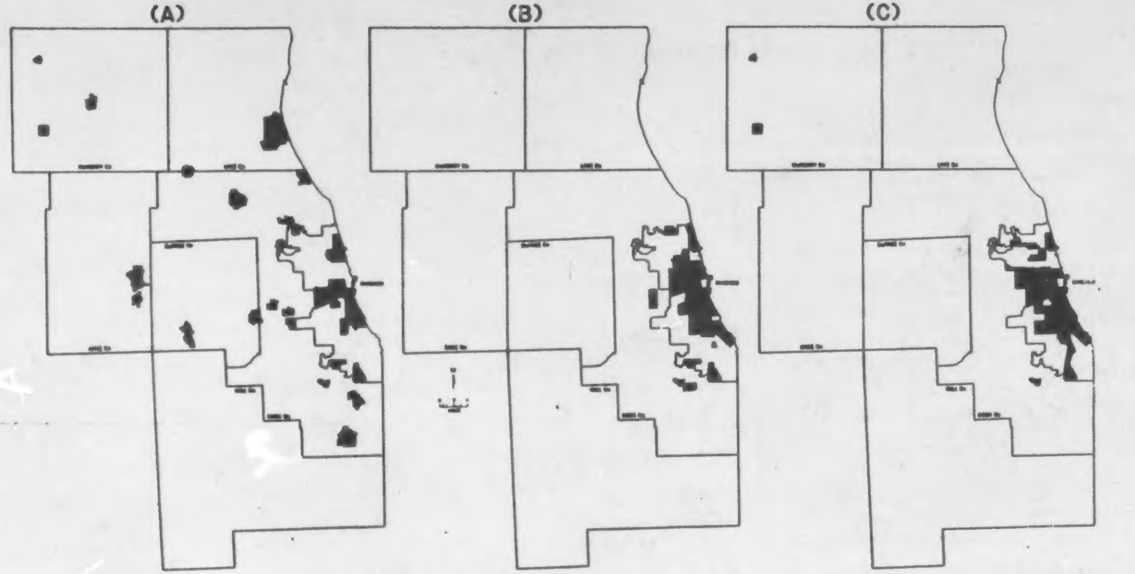
[3] Donald Dewey, Foreign Medical Graduates: Sources, Growth, Geographic Distribution and Locational Factors in Metropolitan Chicago, 1950-1974, DePaul University 1979, funded in part by a grant from the National Center for Health Services Research, Public Health Service, USDHEW.



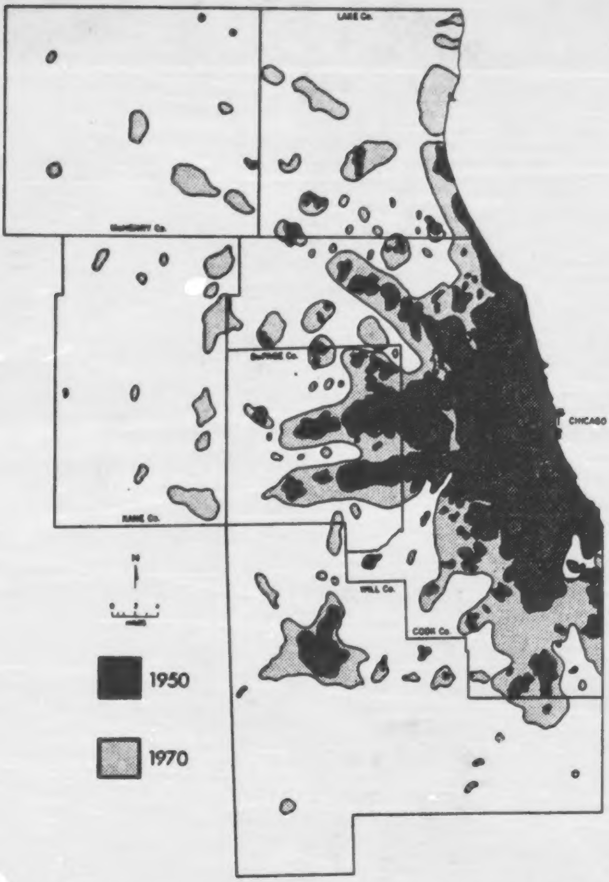
MAP 1

DISTRIBUTION OF BLACK POPULATION IN THE CHICAGO SMSA, 1950, 1960, 1970



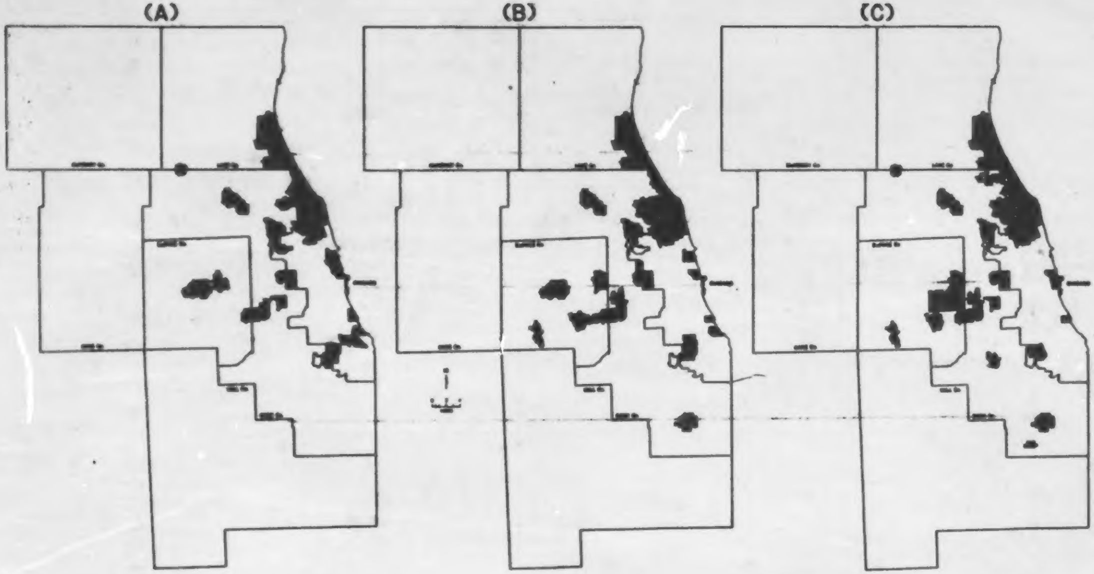
Map 2
Figure 7
DISTRIBUTION OF LOW INCOME POPULATION/1000 POPULATION IN THE CHICAGO SMSA, 1950, 1960, AND 1970

MAP 3


LAKE Co.
McHENRY Co.
DuPAGE Co.
KANE Co.
CHICAGO
WILL Co.
COOK Co.
N
MILES
1950
1970

DISTRIBUTION OF POPULATION IN THE CHICAGO SMSA,

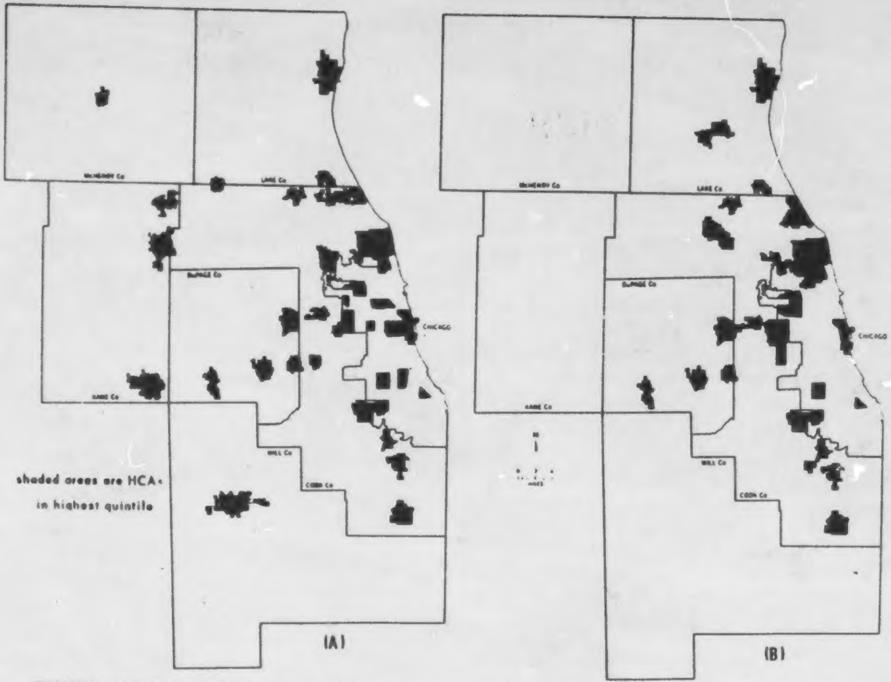
1950 AND 1970



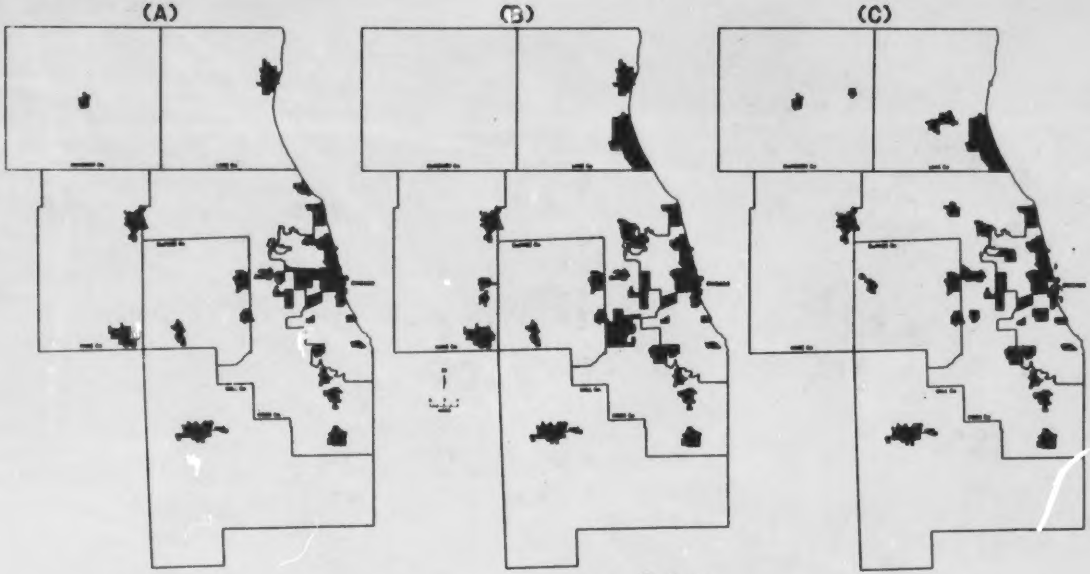
MAP 4

DISTRIBUTION OF HIGH INCOME POPULATION/1000 POPULATION IN THE CHICAGO SMSA, 1950, 1960, AND 1970

MAP 5


McHENRY Co
LAKE Co
DuPAGE Co
KANE Co
WILL Co
COOK Co
CHICAGO
shaded areas are HCAs
in highest quintile
(A)
(B)

DISTRIBUTION OF RETAIL VOLUME/1000 POPULATION IN THE CHICAGO SMSA, 1950 AND 1960



MAP 6

DISTRIBUTION OF HOSPITAL BEDS/1000 POPULATION IN THE CHICAGO SMSA, 1950, 1960, AND 1970

Total population expanded into the suburbs in fingerlike projections along principal transportation arteries. Black and poor poputions became increasingly concentrated in highly segregated sections of the city. Affluent population shifted into the suburbs along the northern lake shore, in a beadlike string of western suburbs, and in a few isolated far southern suburbs. Retail centers were fairly widespread reflecting the general population distribution and hospital facilities were concentrated in the city, larger close-in suburbs and satellite towns.

The changing distribution of these SED factors was compared to the shifting geographic patterns of physicians employing both statistical techniques and visual comparisons of maps. This was done for total, office-based and hospital-based physicians in 1970 and 1974, at four levels of geographic detail i.e., Metropolitan Area, city vs. suburbs, concentric ring and sector zones, and neighborhoods. These analyses indicated that physicians left the city faster than the population and that they continued to prefer to practice in white high and middle income suburbs, leaving poor and black inner city populations medically underserved.

The following examples illustrate this. The Index of Dissimilarity (D_A) (see appendix) between areas with large concentrations of blacks and USMGs in 1974 was very high which indicated they avoid locating in the same areas. On the other hand, there were low D_A values between the physicians and wealthy populations which shows a preference for physicians to locate in areas with large concentrations of wealthy population. Other statistical tests and comparison of maps 7-9 with 1-6 further subustantiated these findings. There continues to be vast disparity between the physician/population ratios in rich vs poor and black neighborhoods of the Chicago SONSA. Such persistent vast disparity requires continued and increased effort to encourage more doctors to provide care for the critically unmet need in underserved areas.

Recommendations

Part of the reason for the continued trends in the location of physicians in large metropolitan areas may be that the existence of doctor poor areas and doctor rich areas in the same metropolitan region has been described as simply a maldistribution of physicians. Actually, the maldistribution results from a more basic problem, that is, a shortage of primary care physicians. Though the total physician/population ratio has increased during the past 20 years, the OB physician/population ratio has been declining. The decrease in OB practitioners coupled with the effects of specialization[4] and the drain of doctors into non-patient care professions--as hospital administration, government agencies, medical insurers, and industry--has created real shortages

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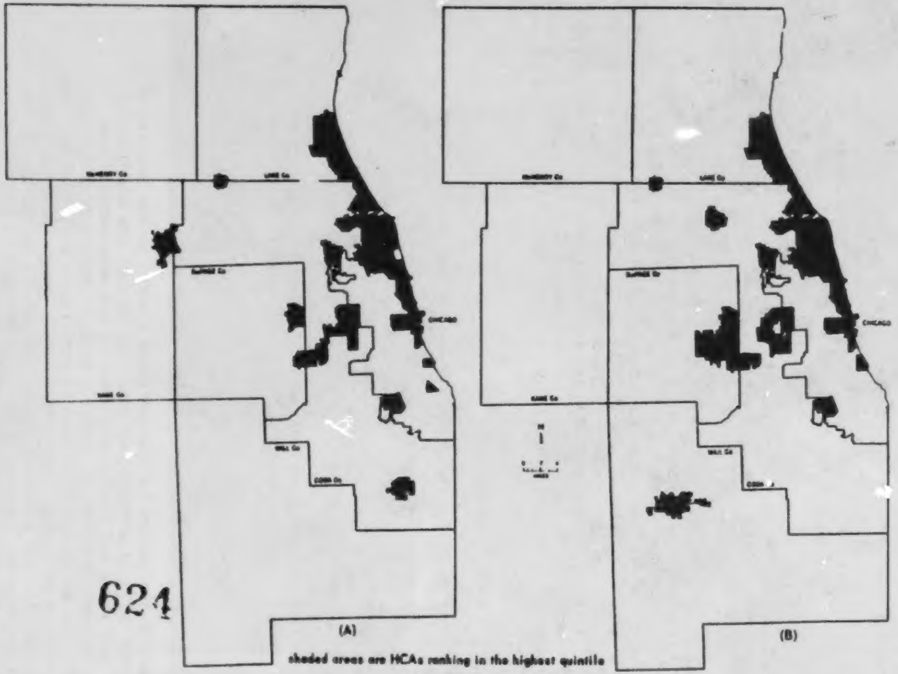
[4] Increased specialization has the effect of lowering the physician/population ratio by increasing the number of doctors needed to meet the medical care needs of the family.

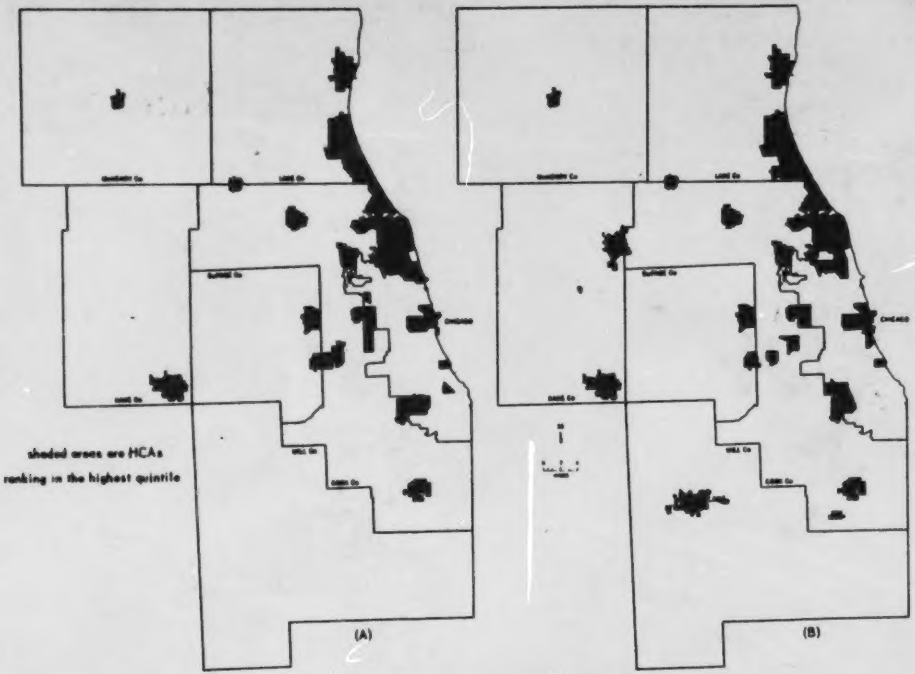
MAP 7


McHENRY Co
LAKE Co
DuPAGE Co
KANE Co
WILL Co
COOK Co
CHICAGO
(A)
(B)

shaded areas are HCAs ranking in the highest quintile

DISTRIBUTION OF TOTAL USMGS/1000 POPULATION, 1970 AND 1974

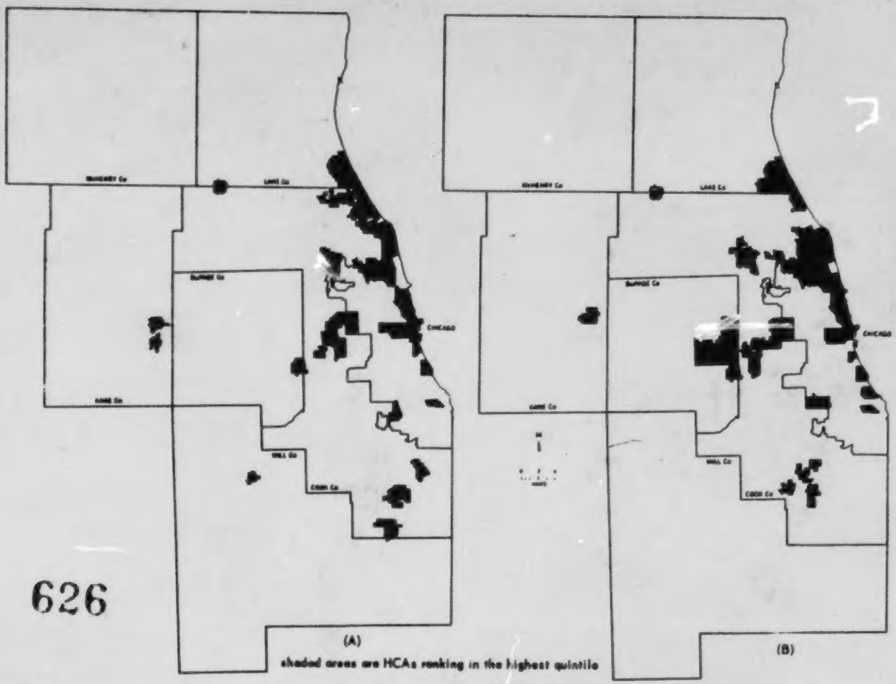
MAP 8



shaded areas are HCAs
ranking in the highest quintile

DISTRIBUTION OF OFFICE-BASED USMGS/1000 POPULATION, 1970 AND 1974

MAP 9


McHENRY Co
LAKE Co
DuPAGE Co
KANE Co
WILL Co
COOK Co
CHICAGO

(A)

(B)

shaded areas are HCAs ranking in the highest quintile

DISTRIBUTION OF HOSPITAL-BASED USMGS/1000 POPULATION, 1970 AND 1974 of primary care physicians.

As long as the demand for primary care physicians in doctor rich areas is great enough to absorb the limited supply of primary care physicians, needy areas will be unable to attract adequate numbers of private practitioners. This suggests three possible solutions to the problem: increasing the supply of primary care physicians, encouraging physicians to provide some form of itinerant service in medically underserved areas, or regulating distribution of primary care physicians within the metropolitan region.

Increasing the supply is more in keeping with the principles of a free market. Incentives in the form of increased financial aids to those students who will commit to entering general practice, or primary care specialties such as family practice, might be effective in encouraging more students to select this type of practice. Tax benefits to physicians practicing in primary care may provide further incentives for remaining in primary care practice. It might also be helpful if the medical or premedical curriculum included required courses to inform prospective doctors of the shortage of primary care physicians in the nation's metropolitan areas.

We should also try to discourage medical doctors from entering professions which do not require extensive and expensive medical training. For example, those not practicing medicine could be required to repay the portion of their educational expenses subsidized by the government.

Medical schools must be encouraged, through financial incentives or obligations placed on funding, to accept some of the many highly qualified candidates now being refused access to a medical education. It is important to note that of all the suggestions for increasing the supply of primary care physicians, only this one requires enlarging medical schools.

Increasing the supply of private practitioners may provide the potential for increasing the physician/population ratio in underserved areas but will not provide motivation for physicians to locate in inner city areas. Fear of personal injury or property damage and theft, real or imagined, deters many physicains from establishing offices in the inner city and has led to the flight of some doctors from these areas. Some doctors who would not consider practicing full-time in the inner city might be willing to serve one day a week in government sponsored HMO or outpatient clinics in these areas if adequate medical facilities and hospital backup were provided. Physicains of the National Health Service Corps. could provide additional manpower to these clinics through assignment to fulfill their obligatory service there. Also, if the military draft is reinstituted, medical students could be given deferments with obligations to serve in doctor poor areas in lieu of military service after graduation.

If incentives and a shifting of emphasis in medical education do not succeed in increasing the supply of primary care physicians for medically underserved areas and physicians cannot be encouraged to serve at least part time in inner city clinics, regulation of distribution of these pyysicians might become necessary. This could be accomplished by a licensing system within metropolitan areas. When the disparity in the physician/population ratio between subdivisions of a metropolitan region reached a given point, say five or six fold, new licenses to practice in doctor rich areas would be denied until the disparity on physician/population ratios decreased to a predetermined acceptable level.

As undesirable as 'forced' ditsribution may be, it has helped to make improved education and adequate housing more accessible to all. Health care is no less important a right than schooling or housing.

APPENDIX I

STATISTICAL METHODS USED IN STUDY

Index of Dissimilarity

The description of the index of dissimilarity is adapted from: Peter Taylor, Quantitative Methods in Geography: An Introduction to Spatial Analysis, Houghton Mufflin Company, Boston 1977, pp. 179-181. The index of dissimilarity (D_A) is a statistical measure of the amount of areal association between two distributions. The D_A measures areal association from a Lorenz curve. The Lorenz curve is a method of plotting two variables on a graph to illustrate the similarities in their areal distribution. If both variables are located in the same place in an area the resulting curve corresponds to the diagonal on the graph. Deviation from the diagonal represents differences in the location of the two variables. The D_A measures the vertical distance between the diagonal and the curve. It ranges from 0% to 100%.

The greater the degree of areal association the smaller the D_A value is. A D_A of 0 means the two variables are located in the same places. A D_A of 100 indicates that where one variable is located the other is absent. The D_A may be obtained by computation of the formula

$$D_A = \frac{|x_i - y_i|}{2}$$

in which x_i and y_i are uncumulated percentages for each variable.

The D_A is particularly suitable for this study because of the property of the index which permits us to interpret the index of dissimilarity as the percent of one distribution which must be relocated to effect an equal distribution of the two variables. We can also assume that a persistently low D_A value between two variables means mutual attraction for each other or some other factor (s). A persistently high D_A means one, or both, of the variables repel the other - or at least they lack attraction for one another.

Mr. **Waxman**. Thank you very much for your testimony.

Dr. Davis, did these areas with only a few doctors have large enough populations to support more doctors—rural areas and urban areas?

Dr. **Davis**. Yes, we do believe that these areas that are underserved could support additional physicians. It is not that they are so small or isolated that there is not a sufficient population base there to support them. We think the reasons these areas have tended not to have an adequate number are related more to professional isolation, the lack of cultural and educational opportunities and that these things really affect the location choices.

Mr. **Waxman**. Over the past 10 years the total has increased by more than 75,000. Where have these additional doctors gone? Have they gone to areas that were already reasonably supplied or have they gone to previously less well served areas?

Dr. **Davis**. It is unfortunate that most of the increase has been in the areas which are relatively well supplied. We found, for example, that looking at just the period for 1971 to 1977 that if you look at the most rural of the counties the increase in patient care physicians per capita has only changed from about 48 per 100,000 to 50 per 100,000, in other words an increase of 2 patient care physicians for an increased population, while if you look at urban areas it has gone up from 146 to 168, an increase of about 22 patient care physicians per 100,000, so the spread between the urban and the rural has really got even worse in this period, not better. Somebody indicated it is more than twice as high in urban areas as in rural and that the spread is a little bit further apart. You break that down to the different States and you find even more dramatic changes.

For example, in Texas the most rural counties increased 4 percent while the very urban areas went up about 29 percent, a very marked difference. In the State of New York, the rural parts of the State, the physician to population went down about 21 percent over that period, while the urban areas went up about 7 percent. So it seems to be getting worse rather than better.

Mr. **Waxman**. Dr. Madison, I understand that you looked at the actual number of new doctors in rural areas over a recent 3-year period. Does your study indicate that many new doctors are locating in rural areas?

Dr. **Madison**. It does not indicate that they are or that they are not. The 3-year period I looked at was a few years back between 1963 and 1966. A lot has happened in the last few years especially because of the National Health Service Corps. It is hard to quantitate exactly how much might have happened since this study, but briefly I will review the results that I found.

Taking only physicians aged 45 and younger who between the years of 1973 and 1976 settled in counties of less than 50,000 people and in towns of less than 10,000 people, I found that 951 physicians, 28 percent of whom were foreign medical graduates, had become new settlers in those kinds of rural communities in the United States within that 3-year period. That is not very many, I would not think.

In addition, the majority, slightly over two-thirds of them, went to communities that in 1973 already had at least three others so the kinds of communities that are the smallest, most out of the way, that once upon a time had physicians and are still asking for a return of the country doctors they once had during the period of 1973 to 1976 probably were not helped very much. On the other hand, in 1977, which was just about at the end of this 3-year period, slightly after that, I also looked at the same kinds of communities against the number of National Health Service Corps physicians who were then in those communities.

Of the 358 physicians who had gone to towns of less than 2,500 population, there may have been a few National Health Service Corps physicians in that number because I was not able to separate those out but knowing the rate of growth of the corps and approximately when it grew I would judge that only a very small number of National Health Service Corps were in that 358. On the other hand, 197 National Health Service Corps physicians were in those same kinds of communities as of the fall of 1977, so I would conclude that since that time and even as of that time the National Health Service Corps was making a substantial amount of difference in these kinds of communities.

Mr. **Waxman**. Before I ask any more questions I want to yield some time to Ms. Mikulski who has a few questions.

Ms. **Mikulski**. Thank you, Mr. Chairman.

I have a question for Dr. Davis. Obviously it is important to recruit people to serve in underserved areas as well as maintain them there. My question to you, Dr. Davis, is what role—and I know we are talking about National Health Service Corps and I have been impressed by the quality of people, many of them are working in Baltimore. What role does our current reimbursement policies play in either creating, perpetuating or exacerbating the physician distribution system that we have? Specifically medicaid, both in terms of inadequacy and real variance which I find rather uneven, has reimbursement policy been a disincentive and a discouragement to people working with the poor, whether it is rural area or urban?

Dr. **Davis**. I think it is one of the factors. There are obviously many factors such as professional association and backup from the more technical resources, but we found, for example, in some States such as Pennsylvania, medicaid is paying about 30 percent of what the medicare program is paying physicians so that the fees can be very low and that is a deterrent to having the physicians locate in areas with a large number of poor people. Even the medicare program has reimbursement rates that vary from area to area and a rural physician could be paid much less for the very same service than in an urban area. One step that we have proposed to try to eliminate some of this difference is to try to bring up rural physician fees and inner-city physician fees to a level that is more like the statewide average. We think that is very important so that there is not a disincentive for physicians to locate in those areas or to serve those kinds of patients. I think it would still take complimentary policies whether it is through the corps or some other programs to really address it.

Ms. **Mikulski**. There is no single strategy to meeting these rather critical unmet needs. We may need a National Health Service Corps to get people in those communities but I would like them to stay not only as National Health Service doctors. It would seem to me that we have to develop other strategies in urban America. Certainly the isolation is not a factor. I have an underserved area within the shadow of major medical universities. Certainly the world community has its own problems. Thank you very much for answering. Of course that reaffirms some of the other concerns I have.

Dr. **Davis**. The other is the eligibility and I know this committee has acted on the child health assurance plan which would expand the eligibility for poor individuals and also try to assure some adequate reimbursement.

Ms. **Mikulski**. I note that 22 percent of the Nation's physicians, as Mr. Cornman indicated, did not serve medicaid patients. Was that your testimony, Doctor?

Mr. **Cornman**. Yes.

Ms. **Mikulski**. Did they give a reason for that?

Dr. **Davis**. You get various reasons. Some of them point to the low fees, some of them point to the paperwork or the delay in payment. It seems to bother the physicians as well. Some of these State programs don't get the checks out as promptly as they might, sometimes State legislatures are trying to save the budget and will delay payments for 90 days or longer.

Ms. **Mikulski**. Thank you very much.

Thank you, Mr. Chairman, for yielding the time.

Mr. **Carter**. Mr. Chairman, if the gentlelady will yield. On that very thing I must say I agree with the point you discussed a moment ago regarding the fact that medicare and medicaid reimburse physicians at lower levels in rural areas; I regret that this is quite true. Physicians also have a lot of paperwork to complete under these programs.

Mr. **Waxman**. That has been one of the problems of getting physicians to take medicare patients.

Mr. **Carter**. Yes.

Mr. **Waxman**. You have a number of different programs over the years trying to attract physicians to rural areas, including the Hill-Burton, the State loan forgiveness program and many others. Dr. Madison, I know you have particular studies on physician recruitment programs in rural areas. Have any of these programs worked?

Mr. **Carter**. Mr. Chairman.

Mr. **Waxman**. Yes.

Mr. **Carter**. May I add something right there? I have heard some of these statements about doctors in rural communities and I feel that the data may not be accurate. Perhaps it was gathered several years ago. From my own experience representing a rural area, I find some of these statements very questionable. Part of the rural area I represent is mountainous, part is farming land, and part is bluegrass, but in almost every county and district I represent a hospital has been built. In virtually every county in which I have held a meeting we have had an increase in physicians. In Bell County we have two hospitals with new physicians. In Russell County, we have also had several new physicians. The same is true for Adair County, which like the other counties is in Appalachia. Also, in Madison County we have a new hospital, where we've had an increase in the number of physicians. There's also been an increase in Rockcastle. Lee County has a HURA project which has brought needed physicians to the area. Jackson, Estill, and Owsley Counties are all part of HURA project, too. Physicians in those areas have come and they are staying. There are two more physicians in Cumberland County, one more in Metcalfe County. So you see that the National Health Service Corps and other programs have helped a great deal to increase the supply of physicians. The situation is not as bad as you describe; it could be worse. Some of these programs have been helpful. We have been working on them for years.

Yes?

Mr. CORNMAN. I hope you were not interpreting that the programs were not being helpful. That was not the intent of it at all.

Mr. CARTER. Probably we have not gone as far as we would like, but the help has been forthcoming and it has led to great improvements. I suggest you review your information.

Mr. CORNMAN. I will be happy to review the information. I do want to make the point, so everybody else is clear, that in stating the figures—which I will look at again—I was not being critical of the National Health Service Corps. As a matter of fact I think, as Dr. Madison is saying, it is one of the programs that has been very helpful.

Mr. CARTER. It has helped in my district.

Mr. CORNMAN. You are saying it. I think you just said those kinds of programs have been helpful, and I want to make the record clear that I am not criticizing those programs.

Mr. WAXMAN. Where is your data from?

Mr. CORNMAN. A lot of different places, HEW, AMA, some from Dr. Madison.

Mr. WAXMAN. How recent is the data?

Mr. CORNMAN. The data I put together for 1977 so it would be—I talked about from the four States was basically data for 1960 through 1977.

Mr. WAXMAN. All right.

Mr. CORNMAN. I can't get much more current than that.

Mr. WAXMAN. Dr. Madison, I was interested in your evaluation of how these programs have worked in the rural areas. Assume they have done some good. How much good have they done?

Dr. MADISON. Well, if I may, let me just before I answer that say something——

Mr. WAXMAN. Maybe I made a statement that is not accurate.

Dr. MADISON. Let me say something from the data that I cited earlier that would support what Dr. Carter said but would also cast some question as to whether his experience in Kentucky is represented. Of the 951 physicians, Dr. Carter, that went to these kinds of places, within that 3-year period, Illinois had the most of any State. Kentucky had the second most. So for whatever reason, I think most of them or the ones you cited have had a very successful experience compared to many other places.

Mr. CARTER. Mr. Chairman.

Mr. WAXMAN. Yes.

Mr. CARTER. How many NHSC people have we had in our area?

Dr. **Davis**. Dr. Carter, I believe currently there are 39 Service Corps in the State of Kentucky and about 20 different sites.

Mr. **Carter**. Twenty different sites?

Dr. **Davis**. Yes.

Mr. **Carter**. I was thinking of the ones in the counties I mentioned earlier, in Jackson, Lee, and Adair.

Thank you Mr. Chairman.

Dr. **Madison**. Mr. Chairman, the problem of the rural physician shortage was not apparent until about 1920. Shortly after the Flexman report began to take its effect in many of the medical schools that then existed, most of them were small, most of them were proprietary, but most of them were the traditional producers of America's rural physicians. It was not the only reason but as they closed the rural physician shortage began to be felt and it got worse during the years. Some corrections were tried before World War II but most of those were local in their impact.

A physician would be provided an incentive by a community—maybe free office space, a subsidy, a place to live, things like that. But after World War II the problem got much worse. In that period of time there was a flurry of activity. In 1947 or 1948, I am not sure which year, the Hill-Burton program was enacted and one of its purposes was to provide hospitals to make up for the very severe deficit of hospital beds but inherent in the program was the notion that that would retract and replace some of the physicians that the rural areas had lost over the years.

Another program about the same time was enacted by the Commonwealth of Virginia in 1946. They enacted the first of a series of State programs that helped medical school students through medical school in return for a subsequent promise to practice in a rural area. In the years following that North Carolina established another program the next year and over the 4 or 5 years afterward almost every Southeastern State and many of the Midwestern States enacted similar programs.

There have been other programs since then. It is very difficult to know what the effect has been. What we do know is that during the time that these programs were in effect the problem continued to worsen by national data. What we don't know is how much worse it may have gotten were it not for these programs. However, the problem certainly did worsen and it was not until very recently that very many people were saying it may be starting to get better and we still don't know for sure whether it is getting better but it is worthwhile now to look at the data very closely I think in the years to come.

Mr. **Waxman**. I understand you referred to the direct programs as opposed to indirect programs. Can you explain these terms to the committee and are you pessimistic that the indirect programs will provide adequate numbers of physicians to rural areas.

Dr. **Madison**. I refer indirectly to all of these previous programs beginning with the Hill-Burton program and the student loan programs and so forth. What I mean by that is that they are recruitment programs that make the following assumption. If the goal is more doctors per rural areas, then we put in place some condition that will make more doctors likely to go to rural areas and hope that they will given that condition but the point is that they would then go there of their own volition and set up practice without any special support other than this particular incentive that is there, essentially as private entrepreneurs. No one would be taking them by the hand making sure that they got established and supporting them in some kind of organized system once they were established. That kind of program I refer to as a direct program.

I think both kinds of programs are necessary. I think that the selection of more people who were raised in a rural culture, had early socialization in a rural area has been proven to correlate possibly with their later settlement in a rural area. That is an indirect kind of intervention that medical school can do but if a person who grew up in a rural area then goes through the professional socialization that happens in medical school and subsequent training and becomes a specialist, there in effect is no longer any possibility that that person will go to a very rural area because specialists require larger population bases to carry on practice and they require all sorts of things that rural areas don't provide.

So it is also necessary to provide the kinds of training programs that will help put the set of skills on the physician that will make that person likely to fit in rural area but that in my view is still not enough because most physicians who come from rural areas and who are trained in primary care will continue to settle in the places—they may go to rural areas but they will center in the larger central places within the rural areas. Places that already have a medical community and the out of the way places that once had country doctors and are still trying to have them return will be unlikely to get them without some direct intervention in addition. So I support all of it and I think that leaving out one of those things will jeopardize the success of the efforts that are now being made to try to equalize the geographic distribution of physicians.

Mr. **Waxman**. Dr. Davis, how would you characterize the impact of medicare and medicaid on the underserved areas?

Dr. **Davis**. I think that it has been helpful to a certain degree. I think the medicare program has had a bit more of an impact, in both the innner city and the rural areas you tend to have a high proportion of aged people so getting better coverage has certainly been a helpful factor there. Medicaid I think has been less of assistance in part because it tends to cover very few rural people. Most rural poor, about 70 percent of the rural poor, are two parent families, they don't get covered under the aid to families with dependent children and therefore don't get medicaid. A lot of the rural poor simply don't get covered under medicaid and then you couple that with the fact that in many instances medicaid is paid very low fees. Medicaid has had less of an impact. I don't know whether Dr. Dewey could add to that from the urban situation.

Dr. **Dewey**. We have found in Chicago that a physician is making up to $50,000 and greater in medicaid practices and that the number of physicians per thousand population decreased right beside. So there would be one doctor doing all of that kind of practice rather than it increasing the numbers of doctors in the area.

Mr. **Waxman**. What would you expect the situation to be if medicaid were not there?

Dr. **Dewey**. It would be that those people would not be able to go to that one doctor, that is what it would mean. But what it means to those people is that they sit 8 hours to wait to see that doctor. They wait 2 to 6 weeks in order to get an appointment to maybe see a doctor of that nature. We have had people die waiting to see the doctor, fall dead waiting to see the doctor, 8 hours.

Mr. **Carter**. Where is that?

Dr. **Dewey**. In Chicago, in the inner city.

Mr. **Waxman**. Do you have any other questions?

Mr. **Carter**. Yes, I have one or two.

I am surprised that in a metropolitan area you do have instances where patients have died waiting for doctors.

Dr. **Dewey**. No one takes them on and only a few doctors will handle that practice.

Mr. **Carter**. Actually with all its inequities Medicaid is a boon to many of us and in many areas. I regret that it is not of more help to physicians in some areas than it is to others but it is a help anyway.

Also, I think that what has been done by this Committee over the years has proved helpful, although we may have overdone some things such as the buildings of hospital beds with the Hill-Burton legislation. In fact, I believe, we have as many as 130,000 extra beds in this country. Some of them might well be in the district I represent. But in general these beds have put to good use. The National Health Service Corps is another program developed through the action of this committee in about 1970. As a result of that we have had a good deal of success in bringing health personnel into medically underserved areas.

Also, the health professions legislation has been extremel helpful. We have seen the number of medical schools in our country go from about 77 in 1965 give or take 10 to 125 at the present time. As a result, recent projecitons estimate there will be approximately 600,000 physicians by 1990. Do you think this increased supply will affect the number of physicians going to shortage areas?

Dr. **Davis**. Well, the increase in overall supply may have some effect on these underserved areas but if we look back at this period from 1971 to 1977 we did have an increase in physicians per capita of about 14 percent but in most rural areas it only went up 4 percent so you had a big increase in the supply and they still were not going into the most isolated areas. It helped some but I think not as much as we would like.

Mr. **Carter**. I have one of the most rural districts in the United States and there are two new doctors there where I live two new doctors in Cumberland, a neighboring county. I think your figures must be a little bit skewed. Of course there are mountains still to climb and many things to be done. I was an MD in an Appalachian area and I enjoyed it. I was able to build a clinic without Federal aid, by the way. I really don't think such aid is necessary anywhere that a physician has the grit to work hard and see medicare patients. He can make a decent living, too—at least I think so.

Would you comment on the RAND study which, as I understand it, reports that some specialists are going to smaller towns and cities?

Dr. DAVIS. Well, I have looked at that study and as I indicated we have not found that these physicians are going into the worst areas. Some of them are going into rural areas but into the somewhat larger towns. The poorest counties and the most rural counties are not having as much of an increase. Plus I am somewhat concerned about trying to rely upon specialists to provide primary care. Such physicians we know, first of all, are more costly, they tend to have fees that are about 50 percent higher than primary care physicians. They are less likely to accept medicaid patients than primary care physicians and they are not specifically trained to provide preventive and primary care. So I think there should be some concerns about whether it is even desirable to be trying to increase the number of specialists in some of these areas.

Mr. CARTER. Of course we see physicians go into what we call growth areas. Some of these areas may not be so large, 20,000 to 50,000, something like that or maybe you might lower that and say 12,000 or 10,000. I can name such areas as that of primary care physicians and different specialties represented. Bowling Green, Ky., is an excellent example of that where practically every field is covered except for the subspecialties. We still don't have enough primary physicians but we have tried, have we not? And for what reason have our efforts been unsuccessful?

Dr. DAVIS. I would not say they have been unsuccessful. I think you have to keep the time in mind. The National Health Service Corps Act was passed in the early 1970's and by the time the students get through their scholarship and some additional training, we are just now starting to have a step up in the size of the corps practicing in the field. I think we will have more of an impact there. Some of the other programs, such as the area Health Education Centers program, the health in the rural areas program, even the Rural Clinics Act was just passed in 1977 and it is starting to have some impact in terms of getting reimbursement to some of these areas. So a lot of what we have done, I think we consider the cup half full rather than half empty. I think we have a lot of improvement to make in this area but we have had some programs that will be making a dent in some of this over time.

Mr. CARTER. Actually they have made a great impact as shown by the increased in the number of hospital beds and the projected increase of physicians by 1990.

Do you approve of the proposal to increase the interests rate on HEAL loans from 12 percent to whatever the market will bear?

Dr. DAVIS. I note that is a fairly controversial feature but I think we are concerned about subsidizing the interest for these physicians. We would rather put a lot more emphasis upon the National Health Service Corps in the way of getting financial support to students.

Mr. CARTER. What are you going to require of the National Health Service Corps?

Dr. DAVIS. That they basically provide a year service for every year of scholarship.

Mr. CARTER. Where?

Dr. DAVIS. In an underserved area either rural or urban.

Mr. **Carter**. Well, do your figures show that National Health Service Corps people have gone into rural areas principally or to the deprived urban area?

Dr. **Davis**. Yes, for the National Health Service Corps we have developed a process of really trying to designate the areas most underserved.

Mr. **Carter**. And they have gone into these two areas. Have they gone into any other area?

Dr. **Davis**. Under the corps program we don't place them in overserved areas or well-served areas.

Mr. **Carter**. Have any gone into the Public Health Service Corps? What percentage of them?

Dr. **Davis**. I am not sure of the figures on those.

Mr. **Carter**. Ma'am?

Dr. **Davis**. I am not sure of the figures on that.

Mr. **Carter**. Could you get me the figures for that please?

Dr. **Davis**. Yes.

[The following information was received for the record:]

Of a total current enrollment of 1,998 in the National Health Service Corps, 987 or 51 percent, are PHS Commissioned Corps members.

Mr. **Waxman**. We will leave the record open. I thought one of the interesting statistics in your testimony was that you estimate that in 1990 up to 16,400 additional physicians in midlevel professions would be needed in medically underserved areas, facilities of 5,200 in inner cities and 3,700 in prisons and mental institutions.

Thank you all for your testimony.

The statement of Herman E. Olsen, president of the American Chiropractic Association, will be made part of the record.

[The statement referred to follows:]

HERMAN E. OLSEN, D.C.
President
AMERICAN CHIROPRACTIC ASSOCIATION

Statement on H.R. 6802

Before the

Subcommittee on Health and the Environment
Committee on Interstate and Foreign Commerce

March 26, 1980

The American Chiropractic Association, the largest chiropractic professional organization in the United States, requests this Committee to rectify certain unfortunate aspects of the current operation of the National Health Service Corps which are detrimental to the best interests of the American people.

This program, conceived some 9 years ago, is a valuable vehicle for providing health care services to millions of Americans who otherwise would not easily be able to secure such health services in their home areas. According to the testimony of Surgeon General Julius B. Richmond, HEW's Assisting Secretary for Health, testified before Congress this past January that there are "746,000 people who today rely on Corps personnel for their continuing health care, people who 9 years ago had no regular doctor." Today there are 1,400 health personnel "on duty in remote rural areas, in small cities, and in poor urban communities where doctors have not chosen to serve voluntarily. He said that this program was authorized to operate in 1700 areas of the United States.

The Problem

HEW refuses to include doctors of chiropractic in the National Health Service Corps although it is authorized by the present law to do so. HEW's unjustified refusal is discriminatory against the millions of Americans who wish to have chiropractice health care. HEW's action is also inconsistent with the purpose of the program which Dr. Richmond described as "providing health services for populations who lack them." This obstructive Federal action is incomprehensible to communities who have sought chiropractic care under this program and have been rebuffed by HEW.

The present law authorizes HEW to

> "...conduct at schools of medicine, osteopathy, dentistry, and as appropriate, nursing and other schools of the health professions and at entities which train allied health personnel, recruiting programs for the Corps and the Scholarship Program," 42 U.S.C. Section 254d(b).
> (Underlining supplied)

HEW Frustrates Congressional Intent

This Committee and the Committee on Ways and Means have only recently approved H.R. 3990, section 20 of which reaffirms the long-standing Congressional determination that chiropractic health care is, and will continue to be, an established part of the health services rendered under the Medicare program. In total disregard of this Congressional intentions, HEW refuses to provide chiropractic services for senior citizens living in health manpower shortage areas. Such deliberate disregard for Congressional intention is all the more indefensible since Surgeon General Richmond told this committee that

> "The data show that shortage areas generally are characterized by high poverty levels, a high percentage of elderly, and infant mortality rates." (Underlining supplied)

Thus, although the Congress and this Committee have specified that chiropractic health service is a key service to the elderly under Medicare, HEW thwarts your Congressional objective by refusing to use its authority to make chiropractic

Corpsmen available to senior citizens in health manpower shortage areas.

It is unnecessary to discuss here the nature and value of chiropractic health services, since this Committee and the Congress - by recent actions - are fully aware of them. However, it is important that in carrying out the intent of Congress, HEW should not be allowed to thumb its nose at Congress by an arbitrary action in refusing to include chiropractors and chiropractic students in the National Health Service Corps.

The Remedy

American Chiropractic Association respectfully suggest that there are two ways in which this unfortunate situation can be rectified, in the public interest. First would be to amend H. R. 6802 so as to include chiropractic specifically in Section 254d(b).

A second alternative would arise if the Committee feels that such amendment is not necessary because the authority is already provided in current law. Then this Committee could do what a conference committee did in connection with H.R. 3892, which became PL 96-151, where the original Senate version would have provided out-patient chiropractic care for veterans. There the Conference Committee determined that current law already authorizes such chiropractic health service without amendment and therefore directed the VA to exercise such authority accordingly. The Conference Committee said as follows in its report on H.R. 3892:

> "It is the understanding of both Committees that the VA generally has authority, which it has to date chosen not to use, to provide chiropractic services directly through chiropractors whom it may employ, as part of hospital care as defined in section 601 (5) (A) (i) of title 38 and medical services as defined in section 601 (6) to

> any veteran eligible to receive such care or services who is in need of chiropractic services, and to provide such chiropractic services on a contract basis under the general criteria prescribed in section 601 (4) (C) for the provision of care and treatment on a contract basis...(B)oth Committees disagree with the VA's position that it should refuse to provide chiropractic services to veterans in every case and believe that chiropractic services for the treatment of musculoskeletal conditions of the spine may be beneficial and necessary in some cases. Therefore, the Committees urge the VA's Department of Medicine and Surgery to reevaluate its position and to use its existing authorities to provide, at least on a pilot basis, chiropractic services in appropriate cases as part of the hospital care or medical services furnished to veterans."

In another instance, the Congress went further and legislatively mandated the inclusion of chiropractic health services for Americans living in medically underserved areas, under the Federal Employees Health Benefits Program, PL 93-368. Would it not seem odd for one group of our citizens, the Federal employees, to be granted the mandatory right to obtain chiropractic health services in medically underserved areas while the general public would be denied equal rights in health manpower shortage areas? We believe that such discrimination was never the intention of the Congress.

Recommendations

The American Chiropractic Association respectfully recommends that this Committee either amend the law as we have outlined, or include in its report on H.R. 6802, or any other relevant bill, a mandate to the HEW that it shall hereafter include qualified doctors of chiropractic and chiropractic students in its National Health Service Corps Program both as Corpsmen and as scholarship recipients, on a basis equal with other health professions already included in the program. We also recommend that, in order to do this effectively, the

Committee direct HEW to amend its present descriptive bulletins and applications accordingly. For example, the application form now used lists 24 "services offered or proposed" but ignores chiropractic health services. This change would need to be made if the public is to be able meaningful to take advantage of the Committee's mandate to HEW. Similar changes of other descriptive material would also be necessary.

The American Chiropractic Association appreciates the opportunity to call this matter to the attention of this Committee, and believes that the Committee can importantly improve the effectiveness of the National Health Service Corps by enabling people in areas of health manpower shortage to choose chiropractic or scholarship holders.

Mr. Waxman. This completes our hearing for this afternoon. The subcommittee will meet tomorrow in this room at 10 a.m., for the concluding session on health manpower.

[Whereupon, at 4:45 p.m., the subcommittee adjourned.]

HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE AND NURSE TRAINING ACT OF 1980

THURSDAY, MARCH 27, 1980

House of Representatives,
Subcommittee on Health and the Environment,
Committee on Interstate and Foreign Commerce,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m. in room 2218, Rayburn House Office Building, Hon. Henry A. Waxman, chairman, presiding.

Mr. **Waxman**. The meeting will come to order.

Today we will conclude our hearings on H.R. 6802, the Health Professions Educational Assistance and Nurse Training Act of 1980.

Our first witness this morning will discuss Area Health Education Centers (AHEC's). AHEC's are large, well organized university based organizations established to decentralize health professions education to local communities and hospitals.

Evidence from North Carolina indicates that AHEC's can contribute to better distribution of physicians and other health professions.

Next we will hear from dental students and representatives of the allied health professions concerning their views on the legislation.

Finally a panel of witnesses will discuss aggregate physician supply, particularly the effect of future increases in the supply of physicians on health care costs.

Today's session will conclude the subcommittee's hearings on the health manpower legislation. We have heard from dozens of witnesses and have thoroughly discussed the many issues important to this legislation. Next week we will begin to mark up this important legislation.

Our first witnesses this morning will discuss the Area Health Education Center program. With us today are the directors of three State AHEC programs. They are Dr. Eugene Mayer from North Carolina, Dr. Malcolm Watts from California, and Dr. Merwyn Landay from New Jersey.

Dr. Mayer, if you could begin by summarizing your statement we would appreciate it very much.

STATEMENTS OF EUGENE S. MAYER, M.D., M.P.H., DIRECTOR, NORTH CAROLINA AREA HEALTH EDUCATION CENTER PROGRAM; MALCOLM S. M. WATTS, M.D., PROJECT DIRECTOR, CALIFORNIA STATEWIDE AREA HEALTH EDUCATION CENTER PROGRAM; AND MERWYN A. LANDAY, D.D.S., M.B.A., DIRECTOR, NEW JERSEY AREA HEALTH EDUCATION CENTER PROGRAM

Dr. **Mayer**. Mr. Chairman, it is a pleasure to have the opportunity once again to appear before the subcommittee to discuss the national AHEC program.

The distribution of physicians and other health manpower by geography and specialty with an emphasis on primary care and family medicine is a great concern for millions of Americans.

With its 1971 and 1976 Health Manpower Acts the Congress has adopted several initiatives to deal with the improvement of access to health care of our citizens and one of these programs has been the national area health education center program.

My comments today relate to the history of the first 8 years of the AHEC projects originally funded in 1972. I have been designated to do this by the AHEC directors themselves.

The point we wish to make is simple. The effect of the original AHEC programs in helping to overcome professional isolation in our communities and in helping to improve the distribution of physicians and other types of health manpower is well recognized.

The 1979 report of the Carnegie Council and the 1979 report to the Secretary of HEW to the Congress both attest to this fact. As further evidence I might cite a few brief examples of accomplishments from several of the AHEC projects around the country.

In Illinois 40 percent of the clinical training of all medical students at the University of Illinois now takes place in community settings. One hundred and twelve family practice residency graduates are now serving 42 counties of that State. Most importantly, $70 million in State funds in Illinois have gone into regionalization catalyzed in part by $16 million of Federal AHEC funding.

In North Dakota, AHEC has helped to create a degree granting medical school totally oriented to primary care with all clinical training in regional settings. There have been developments in residency programs as well.

In South Carolina, a similar pattern with extensive off-campus training of medical students and the development of something like 300 new primary care residency positions.

In California, a recent survey of 30 medical service areas in the San Joaquin Valley revealed 20 of these 30 areas had significant AHEC activity. In these 20 areas, 18 had a twofold increase in the number of physicans. In the other 10 areas of the valley with little AHEC activity there was either no increase in physicians or a decrease.

In North Carolina, we have developed 300 new primary care residency positions of which 180 have been in family practice. There is evidence for a major improvement in physician distribution in each region of our State involving most of our rural counties as well as our urban counties.

Federal AHEC funding of $14 million in North Carolina has catalyzed nearly $96 million of State funding for AHEC programs including $23 million of State funds to build educational facilities and family practice training centers in our nine AHEC regions.

The inevitable conclusion that we reach from a review of the accomplishments of the national AHEC program is that it has helped to improve the distribution of physicians in a manner which reflects voluntarism and interinstitutional cooperation between the university; the community and other initiatives such as the National Health Service Corps.

Accordingly, we believe the AHEC program deserves continued Federal support as one of a series of initiatives designed to overcome the maldistribution of health manpower.

There are several items in the 1976 statute and/or its associated rules and regulations which hamper the capacity of the various AHEC's to adapt to meet regional needs. These items are listed in our written testimony.

Mr. Chairman, we would like to bring two critical matters before the subcommittee. First, during the first 5 years of the AHEC program our relationship with the Federal Government was based in the 5-year incrementally funded contracts which were subject to annual review of program performance and to annual appropriation of funds.

Since 1977 our relationship has been based in but 1 year contracts which severely complicates long-range planning and the recruitment of physicians and others to AHEC activities.

We strongly urge a return to 5-year incrementally funded contracts if that is possible.

While the Congress has treated the originial AHEC projects most fairly we believe there is much more that can be accomplished by building on the base that has already been put into place.

We suggest for a minimal investment beyond the anticipated termination of Federal funding in September of 1981 that the Congress can assure the development and support of important new health manpower initiatives in the original AHEC projects. All 20 of the projects including the newer ones suggest that provision be made for modest continued funding of the original AHEC projects with some stipulations:

One, that we be required to meet the criteria for AHEC's outlined in the new Health Manpower Act; two, funding be used only to support new health manpower initiatives consistent with the special projects section of the health manpower bill; and three, that the aggregate investment of Federal funds in these projects not exceed 10 percent of all Federal funds appropriated for the national AHEC program.

I appreciate the opportunity to be here. We will be pleased to answer any questions. My colleague, Dr. Watts, will make some comments.

[Testimony resumes on p. 647.]

[Dr. Mayer's prepared statement follows:]

STATEMENT OF EUGENE S. MAYER, M.D., M.P.H., DIRECTOR, NORTH CAROLINA AREA HEALTH EDUCATION CENTER PROGRAM

Mr. Chairman, the distribution of physicians and other health manpower by geography and by specialty with an emphasis on primary care and family medicine is a great concern for millions of Americans. With its 1971 and 1976 Health Manpower Acts, the Congress has adopted several initiatives to help improve access to health care for our citizens. The initiatives include the National Health Service Corps, family medicine and primary care residencies, and physician extender programs. Another Congressional initiative since 1972 has been the National Area Health Education Centers (AHEC) Program.

Since there is no single panacea to a problem as complex as the distribution of physicians, the wisdom of The Congress in supporting multiple initiatives is apparent. We support each of these initiatives especially when they complement their individual effectiveness by working closely together.

The National AHEC Program is based in Sections 781 and 802 of Public Law 94-484 (the 1976 Health Professions Educational Assistance Act). It is a program which links university medical centers to regional education centers in the community so as to decentralize the education of medical students and primary care interns and residents to community settings. This change in the process of medical education is important because it has been shown that by conducting significant portions of the education of students and residents in community settings, these students and residents are more likely to choose primary care practice in an underserved community. Also, by insisting that the regional education center takes on responsibility for continuing education and other educational support services for all types of health manpower in surrounding neighborhoods or counties, one is more likely to decrease professional isolation in these areas and increase the likelihood of recruiting and retaining needed health manpower in underserved communities.

The AHEC Program is an outgrowth of a concept enunciated by the Carnegie Commission in 1972 and funded through the 1971 Health Manpower Act which resulted in AHEC Programs based in 11 medical schools throughout our nation.*

The Carnegie Council reaffirmed its support of the AHEC concept in its 1976 Report which provided further impetus for the AHEC Section in the 1976 Health Manpower Act. Subsequent to 1976, AHEC Programs have been funded in part by the federal government in an additional twelve medical schools.

My comments relate to the history of the first eight years of the AHEC Projects originally funded in 1972, and I have been designated to do so by the AHEC directors. Our point is simple. The effect of the original AHEC programs in helping to overcome professional isolation in underserved communities and in helping to improve the distribution of physicians and other types of health manpower is well recognized. The 1979 Report of the Carnegie Council commissioned by the AHEC projects and authored by Dr. Charles Odegaard, President Emeritus of The University of Washington, and the 1979 Report of the Secretary of HEW to The Congress both attest to this fact. As further evidence, I cite the following examples of accomplishments in the original AHEC Projects.

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*These schools are: The University of California, San Francisco; The University of Illinois; The University of Minnesota; The University of Missouri; The University of New Mexico; The University of North Carolina at Chapel Hill; The University of North Dakota; The Medical University of South Carolina; The University of Texas Medical Branch at Galveston; Tufts University; and West Virginia University.

Illinois:

--40% of the clinical training of all medical students at the University of Illinois now takes place in community hospitals.

--112 family practice resident graduates are now serving 42 counties.

--Retention of family practice residents in Illinois is about 70%.

--Over the past seven years, $70 million in state funds has gone into regionalization catalyzed in part by $16 million of federal AHEC funding.

North Dakota:

--AHEC helped create a degree granting medical school totally oriented to primary care with all training in four regional settings. Since AHEC, there have been 160 graduates of the M.D. Program.

--New residencies entirely due to AHEC have been created. These include four family practice programs (48 residents) and one program each in obstetrics and internal medicine. There were no residencies in North Dakota prior to AHEC funding.

--Of the first 14 family practice graduates, 12 are in North Dakota and nine are in towns of less than 5,000 population.

--State funds have been catalyzed by federal AHEC funds to support the AHEC Program after federal funds are terminated.

--In 1967 North Dakota's ratio of physicians to 100,000 population was 81.2. In 1977 the ratio had climbed to 108.0 This represents a significant advance in part due to the AHEC Program.

Tufts/Maine:

--AHEC has helped create a significant decentralization of medical education to Maine with 18 students receiving the entire third year of medical school in Maine.

--Two new family practice residency programs have been developed and two family practice residency programs have been expanded with AHEC support.

West Virginia:

--AHEC has helped increase primary care residency positions from 14 to 102 in three hospitals with a significant retention in regions served by AHEC.

--Due to university relations through AHEC, there has been an increase in the number of residents who are graduates of American medical schools.

South Carolina:

--AHEC has helped increase primary care residency positions from 69 to 314.

--Medical student rotations to rural areas have increased from 27 weeks to 902 weeks per year.

--Minority physician recruitment program has led to an increase from 39 minority physicians in 1976 to 57 minority physicians in 1978.

California:

--There were virtually no medical student rotations to the Central San Joaquin Valley pre-AHEC. Now there are 120 regular rotations of 1.5 months each. Also 160 rotations elsewhere in AHEC.

--New primary care residency positions have increased from 12 to 90.

--A recent survey of 30 medical service areas in the San Joaquin Valley revealed that 20 areas had significant AHEC activity. Of these, 18 had a two-fold increase in the number of physicians. In the other ten areas with little AHEC activity, there was either no increase in physicians or a decrease.

--Pre-AHEC only three physicians in the San Joaquin Valley had faculty appointments at the University of California/San Francisco; now 75 do which reflects the involvement of private practitioners in the education of medical students and residents.

Minnesota:

--In recent years, 75 percent of medical school graduates have chosen primary care residencies; whereas in 1973, only 33 percent made such choices.

--Between 1970 and 1976 the physician/population ratio improved nearly ten percent in areas outside the major metropolitan areas of Minnesota.

Missouri:

--Major preceptorship programs in dentistry, pharmacy, and medicine with about 2/3 of all graduates choosing primary care.

--Greatly increased strength in allied health training.

--Major program in continuing education via an audio-visual network in rural areas.

New Mexico:

--There have been more than 140 Native American graduates of health professional training programs with more than 85% of graduates employed in programs that serve the Native American population.

--Have developed an emergency medicine system serving the Navajo Tribe.

--New organizational capacity created for Navajo Indians to meet health care needs.

Texas:

--Career development effort, largely in allied health, for Chicanos in Rio Grande Valley. The Texas AHEC Program terminated its federal AHEC relationship in 1978 due to its inability to meet the criteria of the rules and regulations associated with the 1976 Health Manpower Act.

North Carolina:

--There are nine AHECs forming a statewide system involving all four medical schools in the State.

--One-third of the clinical training for all medical students now occurs in AHECs.

--300 new primary care residency positions have been added statewide of which 180 are in family practice.

--Evidence for a major improvement in physician distribution with evidence to link AHEC to this. For example, between 1964-1970 only 22 of the State's 100 counties showed improvement in their physician/population ratio with 51 counties showing a worsening. Between 1970-1977 fully 80 counties showed improvement with only 9 showing a worsening. This improvement is in large measure associated with the AHEC Program and other federal and state initiatives.

--$14 million of federal AHEC funds have catalyzed over $90 million state AHEC funds including $23 million of state funds to build medical education classrooms and family medicine training centers in the nine AHEC regions.

The inevitable conclusion that we reach from a review of the accomplishments of the National AHEC Program is that it has helped to improve the distribution of physicians in a manner which reflects voluntarism and inter-institutional cooperation between the university, the community, and other initiatives such as the National Health Service Corps. In several states, we have also seen the catalytic effect of federal AHEC funds upon both state and local AHEC funds which assures long.term survival of the program beyond the period of federal funding in these states.

Accordingly, we believe the AHEC Program deserves continued federal support as one of a series of initiatives designed to overcome the maldistribution of health manpower. It should continue to be supported by a separate section in the next health manpower act, and we are pleased to see it so reflected in Section 216 of House Bill HR 6802.

The support of The Congress for the AHEC Program notwithstanding, there are several items in the 1976 statute and/or its associated rules and regulations which we believe hamper the capacity of the various AHECs to adapt to meet the varied regional needs of our nation. In some instances, modifications in these concerns have been addressed in HR 6802. The modifications we would propose are as follows:

1. We believe that AHECs should be allowed to be based in branch campuses of medical schools and not restricted only to non-profit community corporations. Broad based community input for such AHECs can be assured through regional advisory committees. The success of the programs in Illinois and other states attests to the fact that branch campuses can effectively serve as AHECs.
2. We believe the request that each medical school associated with an AHEC Program conduct at least ten percent of its clinical medical education in AHEC settings is too demanding and suggest that there be a requirement for such activities but that the level be negotiated by The Secretary and the university contractor. We further believe that only the prime contracting medical school should have to meet these requirements and not necessarily other medical schools subcontracting for AHEC services.
3. We believe the mission of AHEC as an education and training program for the providers of health services must be protected. AHEC is basically not a program for the provision of consumer health education except insofar as it trains providers to do a better job of patient and consumer education. There does, however, need

to be some latitude for urban AHECs to expend some federal funds in such community health education activities.

4. We believe the support provided by AHEC to the National Health Service Corps should be limited to "educational" support services.
5. We believe the requirement that each participating medical school conduct a program for the training of nurse practitioners is inappropriate insofar as medical schools do not conduct such programs.
6. We also believe that the advisory committees of the AHEC Program should be reconstituted in the statute to reflect the fact that the "consumer" of AHEC educational services is really the "provider" of health care in the community. This recognition would help alleviate rigid requirements of HEW regulations with respect to the composition of AHEC advisory committees.

Finally, Mr. Chairman, we would like to bring two other matters before the Subcommittee. First, during the first five years of the AHEC Program our relationship with the federal government was based in five year incrementally funded contracts subject to annual review of program performance and to annual appropriation of funds. Since 1977, our relationship has been based in one year contracts which severely complicates long range planning and the recruitment of physicians and others to AHEC activities. We strongly urge a return to five year incrementally funded contracts to avoid unnecessary bureaucratic red tape while maximizing the capacity of the AHECs to recruit needed physicians and others to faculty positions in the community.

Second, while The Congress has treated the original AHEC projects most fairly, we believe there is much more that can be accomplished in our individual states and suggest that for a minimal investment beyond the anticipated termination of federal funding in September, 1981, The Congress can assure the development and support of important new health manpower initiatives in the original AHEC Projects. Since the organizational network has been built and in many cases taken over by state funding, a modest investment of federal funds through the next health manpower act could see to it that the original AHEC projects continue to meet the health manpower needs of the 1980's. We suggest that provision be made for continued funding of the original AHEC projects with the following stipulations:

1. That the project meet the criteria for AHEC as outlined in the new health manpower act.
2. That funding be used to support new health manpower initiatives that build on the established AHEC structure.
3. That the aggregate investment of federal funds in these projects not exceed ten percent of all federal funds appropriated for the National AHEC Program.

I appreciate the opportunity to appear before the Subcommittee and look forward to answering any questions.

Mr. **Waxman**. Thank you. Dr. Watts?

STATEMENT OF MALCOLM S. M. WATTS, M.D.

Dr. **Watts**. I am Dr. Malcolm S. M. Watts, associate dean of the School of Medicine at the University of California at San Francisco and the project director for the California statewide area health education center program.

Although I have been the director of a rural regional AHEC project in California for 5 years my purpose today is to briefly discuss three statewide programs which were established under the current law and regulations.

The Ohio and Massachusetts projects are in their second year and the statewide program in California is in its first year. Taken together these three programs organize the resources of 18 medical schools to deal with the health manpower needs of States with a combined population of more than 38 million people.

The needs and opportunities vary greatly not only among the States but within them. Our own experiences and the achievements of other AHEC projects makes us confident that we have an effective mechanism for accomplishing our goals.

We are concerned that we should be allowed reasonable flexibility to work best within our own settings; that we have adequate financial support and that the Government will not continue to add to the list of functions of the AHEC programs.

We believe that if the projects are to flourish it is important to have a well understood evaluation mechanism and a consistent approach to the administration of the project by the Federal Government.

Cooperation among the AHEC program and related Federal initiatives such as the National Health Service Corps and the health planning agencies is essential.

Thank you.

[Testimony resumes on p. 659.]

[Dr. Watt's prepared statement and attachments follow:]

STATEMENT OF MALCOLM S. M. WATTS, M.D.,

PROJECT DIRECTOR, CALIFORNIA STATEWIDE AREA HEALTH EDUCATION CENTER

Of the 22 million citizens of the state of California, almost 9 million, 41% of the population, live in geographic areas officially designated, by the state of California or by a Federal agency or by both, as underserved by primary care physicians. Although California is endowed with centers of great excellence in medical research and education and also is the beneficiary of substantial in-migration of physicians from other states, it is plagued by the classical problems of specialty and geographic maldistribution which were identified by the Carnegie Council in its report of 1970 and by subsequent Federal legislation. Almost all of the rural areas of the state are designated as underserved, as are very substantial portions of the populations of the major urban areas, chiefly around San Francisco Bay and the Los Angeles Basin. California also shares with some other states a diversity of special health care needs arising from the concentration of minority ethnic groups in inner city barrios and ghettos, a major population of migrant workers, a significant influx of refugees from Southeast Asia, numerous and widely distributed Native American Reservations and rancherias, growing concentrations of retired persons, and pockets of population distributed in isolated communities at great distance from major medical centers.

Similar problems of shortage and maldistribution exist among other categories of health manpower as well. Moreover, we suffer from a sometimes compartmentalized and uncoordinated approach to the solution of these problems among the many agencies (local, state and federal) which are attempting to address them. Some notion of the complexity of this system of agencies, or "non-system", may be derived from the following brief statistical summary which was compiled in January of 1979:

1. There were 35 areas designated by the Federal Government as health manpower shortage areas.
2. There were 21 California Health Service Corps sites.
3. There were 35 National Health Service Corps sites (some of which were adjacent to the California sites).
4. There were 18 federally-funded rural health programs supported by migrant health initiatives, health underserved rural area initiatives, and rural health initiatives.
5. There were 45 Indian health projects and clinics.

6. There were numerous concurrent awards to the same agencies from the state of California and various agencies of the Federal Government to support primary care physician residency training programs, nurse practitioner and physician assistant training programs, undergraduate education programs, health team training programs, and the like.

I do not imply that these programs are unnecessary or unworthy of financial support. In most cases, these activities are both a manifestation of need for health manpower education and a resource for such training. However, the size and complexity of this system demonstrates a need for collaboration and coordination across agency boundaries and among many competing constituencies. Under these circumstances, both of the components of an AHEC program (a cooperating medical school and a cooperating community agency) may be confused and wary of entanglements without an effective mechanism to deal with this array of programs in which both partners have confidence. So, California is a state which needs both the educational component of an AHEC program and the coordinative organizational system which such a program may provide.

In 1979, the University of California at San Francisco School of Medicine was invited to propose to the Bureau of Health Manpower a plan to develop a statewide area health education center program in California. The University came to the task with some considerable assets, among these were:

1. A very successful experience in operating a regional AHEC in the Central San Joaquin Valley in California for seven years and two other AHECs in the coastal areas of Central and Northern California for two years. This project, developed as part of the first generation of AHECs, was more than a small test run of the AHEC concept; it served a population of 1,973,200 and 37,157 square miles (about twice the size of West Virginia). In the Central San Joaquin Valley Project where our programs covered a sufficient span of time, we were about to establish clear and substantial gains in primary care physician manpower in health service areas where significant AHEC activity occurred and to compare that outcome with a well-documented tendency toward declining physician population and health services in a large adjacent control area. The gains were made, not only by establishing and expanding residency training programs and retaining the majority of the graduates of such programs, but also by developing a broadly based educational and consultative system which reached even the small towns of the area and profoundly affected the professional environment. This

outcome was established in a variety of ways, including a survey of practitioners entering, leaving, and remaining in the area; but it perhaps can best be summarized by pointing to an in-migration of primary care physicians during the period 1975 - 1977 of 197 as compared to an out-migration of 70 primary care physicians, for a gain of 127. Dr. Eugene Mayer, in his testimony regarding the original AHECs, has cited a number of examples of such successes in California and in other states, as have reports prepared by the Secretary of HEW for the Congress, and the report for the Carnegie Council prepared by Dr. Charles Odegaard. In our case, we were fortunate to have some good baseline data and to have the advantage of being able to track changes in the supply and distribution of health providers in a large statistically significant area and in a similar control area. In another study in that same area we were able to establish a change in mortality rate over time, which correlates with educational programs that were focused both as to place and to subject matter. There should always be some skepticism in such studies because of the enormous range of variables that cannot be controlled. However, the University of California became convinced, by this experience and by the measured results, that the AHEC program was indeed successful in causing a profound improvement in the access to and the quality of health care within the AHEC area and that it is an efficient cost-effective way to solve some of our most persistent problems in health manpower distribution. Therefore, both the University of California at San Francisco and the University of California at Los Angeles Schools of Medicine (UCLA had been a major partner in the Central San Joaquin Valley AHEC for five years) were attracted to the possibility of developing a cooperative statewide AHEC program.

2. Other AHEC-like activities initiated by other medical schools in the state which also developed experience in outreach activities and conditioned those institutions to believe in the effectiveness of the AHEC approach to health manpower education. Among many such examples were the broadly distributed network of rural family practice and family nurse practitioner training programs at the University of California at Davis, and the urban health education initiatives of the University of Southern California and the Charles R. Drew Postgraduate School of Medicine in Los Angeles.

3. A State-funded initiative known as the Song-Brown program which provides some 3 million dollars annually to stimulate and subsidize the training of primary care physicians and mid-level practitioners.

4. A network of primary care residency training programs affiliated with medical schools, but well distributed through much of the area of need.

Our proposal was originally submitted as a cooperative program of the five University of California Schools of Medicine with the University of California at San Francisco serving as the lead school and fiscal agent in behalf of the regions. The proposal, however, called for the involvement of the three private schools of medicine during the planning year. It also involved other health professions educational institutions with a total of 15 professional schools contributing to the original proposal.

GOAL

The goal of the project is the same as that which is expressed in Public Law 94-484; to improve the access to and the quality of health care by improving the supply and distribution of primary care health manpower.

FUNDAMENTAL CONCEPTS

Our statewide program is based on the following principles:

1. A genuine partnership must be developed between a participating medical school and one or more area health education centers.

2. Before the partnership may be established, it must be clear that there is a significant need for improved health services in that area.

3. It must be established that the identified health service needs are amenable to educational interventions aimed at the health providers.

4. The cooperating medical school (and its associated schools) must be able and willing to support its interventions.

5. The AHEC, a community-based organization, must be representative of the community and really able to involve the significant provider groups and educational resources in the project.

THE ORGANIZATIONAL STRATEGY IN CALIFORNIA

The 01 Year of the project (it began on July 1, 1979) was to lead not only to the development of a comprehensive plan, but also to the establishment of an effective statewide organization. The organizational strategy was to:

1. Engage all eight medical schools in the project and a broad range of other health professions schools as well.

2. Form an effective working relationship with non-university agencies such as the Office of Statewide Health Planning and Development, the Health Systems Agencies, the California Postsecondary Education Commission, and the California Health Manpower Policy Commission. An example of the desired product of these relationships is to coordinate the allocation of AHEC funds for physicians and mid-level practitioner training with the allocation of the Song-Brown funds for similar activities.

3. Provide for maximum autonomy for each cooperating school within its region of responsibility while insisting on the development and maintenance of integrative project-wide activities; providing for a basic core of similar activities in each new AHEC while establishing a mechanism for discrete awards based on special needs and opportunities in one or more AHECs; establishing a central office to assure coordinated planning, technical support, fiscal and contract accountability, and a common sense of purpose and direction.

4. To avoid doing what is already being done; this implies the development of a capability to know what is going on throughout the state and among the many intertwined Federal and State programs.

5. Develop planning committees relating to each of the functions of the AHEC which would include representatives of the institutions which already are engaged or would need to be involved in AHEC activities.

THE PROGRAM STRATEGY

An enterprise of this size needs flexibility in program planning so that each regional office may respond to local needs and capitalize on local assets, but there also needs to be a sufficient thread of commonality. There will be constant competition for resources and there is always a danger of diluting the effort or of making such rapid shifts in emphasis that the prospects for counting any major impacts will be diminished. The program strategy outlined below, we believe, takes into account both the need for flexibility and for consistency:

1. The focal point for program activity will be the network of affiliated primary care physician residency training programs, especially family practice.

2. The plan of every cooperating center will include activities and resources to add adequate strength to a primary care residency training program and to expand that program or extend its reach to more distant underserved areas, or to establish new training sites.

3. Each center must develop or improve an undergraduate medical education program involving both clerkships and preceptorships, and it must give concurrent and strong emphasis to continuing professional education. The undergraduate, graduate, and postgraduate educational programs must be integrated and reinforce one another with the objective, not only to educate physicians in underserved areas, but also to retain those already in the area, to engage them in the educational process, to advance the skills of health professionals, and to attract physicians from other areas.

4. Although some funds can be allocated to the development of other educational programs from the contract, each center will, insofar as possible, develop such programs in cooperation with other agencies such as community colleges and hospitals which have the capability to continue those programs once they are developed.

5. In selected instances, to develop programs at the regional or statewide level which might have components in the AHECs as well (examples being library and learning resources and drug information services) assuring that for each educational program there is both a local component and a university faculty component. Seek out the existing systems and concentrate on finding the gaps which need to be filled or the integration which needs to be applied wherever possible.

PROGRESS

Some of the achievements of the California AHEC during the first year were:

1. The completion of a Letter of Intent with the Office of Statewide Health Planning and Development and the California Postsecondary Education Commission stating our intention to cooperate fully in the coordination of activities while in pursuit of common objectives. (Appendix I.)

2. Endorsements of professional associations such as the California Medical Association have been received. (Appendix II.)

3. Fifteen planning committees (each relating to one of the functions of an AHEC center and each comprised of 10-15 distinguished educators, providers, and consumers) have been organized, have met three times, and have developed plans and recommendations from a statewide perspective.

4. All eight medical schools have joined as cooperating schools and each has assumed responsibility for a region of the state; four of these schools have staff paid under the contract and the others are donating staff time during this year. A plan has been produced for each of the eight regions of the state.

5. Five new area health education centers are nearing the completion of their planning year and all have produced written plans for their 02 Year; eight more AHECs are in the early planning phase.

6. The Statewide Program Advisory Committee has met three times and has reviewed the recommendations of the fifteen statewide planning committees as well as the draft proposals of the eight regional medical schools and the five AHECs.

7. The eight deans of the cooperating medical schools met on March 13; and after a full day of carefully considering the plans developed and the status of the organization, they endorsed the work that has been done and agreed to proceed with the development of our proposal for the 02 Year.

8. We have accounted separately for the original contract activities, but in terms of planning we have integrated the three AHECs developed under the previous contract with plans for the statewide system. We project that in the course of the next eight years, a total of eighteen centers will be developed, about one-half of which will be urban and one-half of which will be rural.

The planning and development of the project has proceeded much more rapidly than we had anticipated. The planning also has revealed with greater clarity and emphasis the difficulty and the size of this undertaking. As a result of these factors, we have revised our estimate of the funds required to conduct the program and will adjust the projected budget in our next proposal.

APPENDIX I

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO   SANTA BARBARA • SANTA CRUZ

STATEWIDE
AREA HEALTH EDUCATION CENTER SYSTEM

September 30, 1979

LETTER OF INTENT

The undersigned hereby mutually agree that it is their intention to cooperate fully in the coordination of the activities of their respective agencies while in the pursuit of common objectives relating to the training and deployment of health manpower resources in California.

The Office of Statewide Health Planning and Development fully supports the concept of a Statewide Area Health Education Center to improve the quality of services to patients and to design programs to enable health professionals to provide these services in areas and among populations that currently are unserved or underserved. The Office will cooperate to the maximum extent feasible during the Center's planning phase. The Office will, specifically, provide such data and information that it has, on a timely basis, to assist the Center in its planning activities. The Office will make available, as appropriate, staff to participate in the Center's planning operations, for purposes of coordinating policy and planning initiatives. The Office will assist the Center in establishing communications with other agencies and institutions which have major roles in health manpower activities.

The Statewide Area Health Education Center recognizes the Office's mandated responsibilities for health planning and health manpower planning and programming. The Center will take into account, in its planning and resource allocation decisions, the recommendations of the State Health Plan, the California Health Manpower Plan, and the Health Sciences Plan of the Postsecondary Education Commission. The Center will provide adequate opportunities for Office staff to participate in the Center's planning activities through the placement of Office representatives on appropriate advisory and working committees. The Center will share with the Office such data and information that it accrues, that will be useful in the Office's programs and activities.

Henry W. Zaretsky

Henry W. Zaretsky, Ph.D.
Director
Office of Statewide Health
Planning and Development

Malcolm S. M. Watts M.D.

Malcolm S. M. Watts, M.D.
Project Director
California Statewide Area
Health Education Center

Agnes C. Robinson

Agnes C. Robinson
Chairperson
Postsecondary Education Commission

APPENDIX II

cma
CALIFORNIA MEDICAL ASSOCIATION
731 Market Street / San Francisco, California 94103 / 415-777-2000

January 21, 1980

Malcolm S.M. Watts, M.D.
Project Director
Associate Dean
Room 224 - Sciences
San Francisco, California 94143

Dear ~~Doctor Watts~~ Mal:

This letter is to convey officially the California Medical Association Council's endorsement of the objectives and program of the California Area Health Education Center (AHEC) Network as a mechanism to influence the distribution of physicians and other health professionals into both urban and rural medically underserved areas.

May I also extend my personal congratulations to you and Associate Project Director Clark Jones on the progress being made through this complex and innovative program, which shows such promise for improving access to and quality of care in underserved areas.

Sincerely yours,

Brad

Brad Cohn, M.D.
Chairman of the Council

BC:arw

SUMMARY OF THE MASSACHUSETTS AHEC PROGRAM

The Massachusetts Statewide Area Health Education Center Program has been developed as a partnership among three medical schools, a number of other health professions schools and programs, and community-based institutions which have planned and organized AHECs. The University of Massachusetts Medical Center (UMMC) is the prime contractor for the development of the statewide AHEC system. In its first planning year, the AHEC Program made significant progress and accomplished the following:

- A network of health professions schools has been firmly established and reflects the commitment of these institutions to addressing health manpower needs in Massachusetts. In the first year, formal participation in the AHEC Program brought the following schools together: University of Massachusetts Medical School; Boston University Schools of Medicine, Nursing, Dentistry, Social Work, and Sargent College of Allied Health; Tufts University Schools of Medicine, Dental Medicine, Occupational Therapy, and Nutrition; University of Massachusetts School of Health Sciences. Other health professions schools will become formal participants in the AHEC effort during the 02 year.

- Three Area Health Education Centers were established and reflect major commitments of resources by local community institutions. These AHECs are: Berkshire AHEC, Boston AHEC, AHEC of Pioneer Valley. All three AHECs successfully accomplished organizational tasks (area designation, establishment of governing boards and advisory committees) and planned educational programs for the 02 year in collaboration with the various schools.

- The AHEC Program developed cooperative working relationships with other key agencies which have significant roles in shaping health manpower strategies. These include the Massachusetts Office of State Health Planning and the Regional Office of the National Health Service Corps. Similarly, the AHECs established working relationships with their HSAs. Thus, the AHEC Program will play a significant role in shaping policies concerning health manpower development.

- UMMC has been able to secure non-federal, state support for the AHEC Program for the 02 year. This represents an initial effort, which will accelerate in the coming years, to secure non-federal funding for the AHEC Program.

SUMMARY OF THE OHIO AHEC PROGRAM

The Ohio Statewide AHEC Program is a unique cooperative program being developed by Ohio's seven medical schools and the Ohio Board of Regents. All of the medical schools are planning or developing regional AHEC programs that will meet the requirements of Section 781 of P.L. 94-484.

The overall goals of this statewide program are to:

1) Improve the specialty and geographic distribution, supply, quality, utilization, and efficiency of health personnel in the health delivery system, and to,

2) Encourage regionalization of health professions education.

Specifically, Ohio's program is addressing through regionalized education activities those problems associated with a rural Ohio population which has shown an 8% increase while the physician-to-population ratio has remained constant during the same time period. Problems associated with underserved urban areas are being addressed by programs being developed in Cleveland, Youngstown, and Cincinnati.

Organizationally the University of Cincinnati College of Medicine serves as the prime contractor, and then subcontracts with the six other medical schools in the state for the planning and development of regional AHEC programs. Also, the Ohio Board of Regents has subcontracted to provide statewide administration and coordination of the Ohio Statewide AHEC Program. The Regions have established the Ohio AHEC Advisory Board to serve as the statewide program advisory committee to facilitate AHEC program planning and development.

The planning and development activities of the Ohio Statewide AHEC Program are being conducted in phases. The regional programs at the University of Cincinnati College of Medicine and at the Northeastern Ohio Universities College of Medicine have completed one year of planning, and have begun the development of Centers in Georgetown, and Youngstown. The Case Western University School of Medicine is now in its second year and is working toward the development of an urban AHEC in Cleveland. The Wright State University School of Medicine will begin its second year on April 1, 1980 with the development of a Center in Dayton. The Medical College of Ohio, the Ohio State University College of Medicine, and Ohio University College of Osteopathic Medicine are now conducting regional planning activities.

3/12/80mjl

Mr. **WAXMAN**. Thank you very much. Dr. Landay?

STATEMENT OF MERWYN A. LANDAY, D.D.S., M.B.A.

Dr. **LANDAY**. Mr. Chairman, I am pleased to have the opportunity to appear before this subcommittee for the urban AHEC programs.

Nine States now have AHEC programs in urban areas. This includes California, Connecticut, Illinois, Maryland, Massachusetts, New Jersey, Ohio, Pennsylvania, and Virginia.

This movement of AHEC's into urban central cities has occurred in the newer AHEC programs funded since 1977 at the urging of both the House and Senate in reports issued in 1975. Because of their newness the urban AHEC's are still in the planning and development stage.

They are preparing to implement the AHEC strategies that have proved successful in addressing the health manpower and delivery system problems in rural areas. This includes the production of increased numbers of primary care health manpower and mid-level practitioners and attempting to locate and retain them in shortage areas.

In addition urban AHEC's face forces different than rural areas. These include complicated economic, cultural, educational and environmental barriers to the adequate supply of health manpower and the delivery of health care. Because of these barriers most urban areas share the problems of generally higher mortailty and morbidity rates and other indicators of seriously deficient health status.

To deal with these problems will require approaches and strategies different than rural areas. The urban AHEC programs are serving as the vehicle to focus the attention of universities on central city health manpower and health care delivery problems and providing a catalyst to the development of new approaches and strategies to address the problems unique to inner cities.

This development process we believe will be an important contribution of the AHEC program in urban areas and is a most valuable return for the dollar investment the citizens of the United States are putting into this program.

Examples of some of the newer urban AHEC programs in Camden, Hartford, Pittsburgh, and Los Angeles are contained in my written submission.

Thank you.

[Testimony resumes on p. 667.]

[Dr. Landay's prepared statement follows:]

STATEMENT OF MERWYN A. LANDAY, D.D.S., M.B.A., DIRECTOR,

NEW JERSEY AREA HEALTH EDUCATION CENTER PROGRAM

Mr. Chairman: I am pleased to have the opportunity to appear before this subcommittee to present important information on the new Urban AHEC Programs as Health Manpower legislation is considered. In this testimony New Jersey serves as the representative of all of the AHEC Programs with urban responsibility, either those exclusively urban or those statewide with urban components. This now includes California, Connecticut, Illinois, Maryland, Massachusetts, New Jersey, Ohio, Pennsylvania and Virginia.

The problems of health care in urban central cities, as you know, are significant. Similar to rural areas, there are problems of maldistribution of health manpower, both of the geographic and specialty type; along with those of quality of care and levels of care. In addition to these problems, urban AHECs have a number of other issues with which to contend. In central cities there are forceful economic barriers to adequate health care due to large concentrations of indigent populations. There are both cultural barriers due to differences between consumers who are mostly black and hispanic, and providers who are mostly white; and educational barriers with populations which have little knowledge of or appreciation for staying healthy. And finally, there are significant environmental factors such as high crime, decaying neighborhoods, pollution, etc. All of these forces interact, even synergistically, to erect barriers to the adequate delivery of care in central cities. Because of these barriers, many if not all urban areas share the common problems of generally higher mortality and morbidity rates, high infant mortality rates, high teenage pregnancy rates, elevated veneral disease rates, high drug and alcohol abuse rates, and other indicators of inadequate health status.

Urban AHECs were first proposed to address some of these problems by the 1970 Carnegie Commission Report, Higher Education and the Nations Health, and were authorized and established under the Health Manpower Education Initiative Awards, Section 774(a) of the Public Health Service Act as amended by P.L. 92-157, The Comprehensive Health Manpower Training Act of 1971, and P.L. 94-484, The Health Professions Educational Assistance Act of 1976, Section 781. Until 1977, however, AHEC development focused almost exclusively on rural areas. In 1975, a House of Representatives Committee Report on the Health Manpower Act of 1975 (Report No. 94-266) stated:

> "The only overall criticism . . . . (of) the AHEC Program to date is that none of the existing AHECs have been directed toward the health manpower problems of innercity urban areas. The committee expects that a significant portion of AHECs developed under the new legislation will be designed to influence geographic distribution problems in these areas."

The Senate's Labor and Public Welfare Committee Report (No. 94-887) on the Health Professions Educational Assistance Act of 1976 also called for "the establishment of AHEC programs which serve urban areas" and recommended that foremost consideration be given to making new AHEC awards in the innercities. The 1976 Carnegie Council Report also identified the innercity as one of the areas most in need of AHEC development. The oldest urban AHEC, therefore, is now about three years old; with most still in their planning and development phases, and none yet fully operational. For this reason, hard data on the accomplishments of urban AHECs is not yet available. We will, however, describe a few of the specific AHEC programs in central cities to give you an idea of what is planned. But, before describing projects, I think it is important to look at what many feel will be the largest single general outcome from the urban AHEC programs.

To those involved with health care and central cities, it is evident that the urban AHECs are not just a repeat of rural AHECs in new locations. Those in the AHEC business know that in urban areas we are in a somewhat different ball game. In some urban areas, there are shortages of health manpower; while in others there are large numbers of physicians, dentists, nurses and other health manpower. In both of these situations, health status indicators are seriously deficient. The common denominators are not just shortages of manpower and poor health status. What we now understand is that urban AHECs will need newly created approaches and strategies in addition to those developed and found successful in rural AHECs. This developmental process, we think, will be the most vital contribution of the universities which are taking AHEC contracts in urban areas.

The early urban AHEC programs find themselves as pioneers similar to the initial rural AHEC programs in 1972. While in my sister states of North Carolina and California testifying here today and in others, strategies have been developed for rural area health care problems that are beginning to show substantive results, in urban areas we are in the beginning of this process of more clearly defining the problems and developing strategies to remedy them. On the urban health care scene, there are few actors directing their attention to this task. The National Health Service Corp and the Urban Health Initiative Program are important for providing direct services in the gaps that now exist. The universities, however, are more appropriate for the role of developing new approaches to the health care manpower and delivery dilemmas in urban central cities. They have the appropriate creative resources. The AHEC Program serves as both the vehicle to focus the universities' attention on urban central city health manpower and health care delivery problems, and the catalyst to this developmental and creative process. The search for new strategies is now underway in all of the new urban AHEC programs. This, we believe, will be the most important contribution of the AHEC Program in urban areas, and is a most valued return for the modest dollar investment that the citizens of the United States are putting into this program.

The urban AHECs are also preparing to implement many of the strategies that have been successful in rural AHECs. As examples, I will describe a few of the AHEC programs being planned for central cities. New Jersey, my state, will be interesting to watch as it is perhaps the most urbanized state in the United States with about a dozen SMSAs. The AHEC Program in this state is being conducted under contract with the College of Medicine and Dentistry of New Jersey. We presently plan two urban AHEC centers in Camden with a subsequent one in Trenton or Vineland. If we achieve success in finding useable remedies for urban problems, we will seek a state, federal partnership to extend the models we develop into urban areas throughout the state. In Camden, our first site, as a critical by-product of developing educational programs, we are bringing comprehensive primary care health services to innercity residents who have not had the good fortune of having neighborhood health centers in their central city. To do this, we are developing three innercity family practices in newly built centers that will provide comprehensive patient care through a partnership between the Camden County Health Department and one of our medical schools. These health centers will be staffed by medical faculty, students and residents to both render comprehensive family practice care as well as to provide family practice medical education. Participating also in these AHEC centers will be the School of Allied Health Professions with its Physicians Assistants Program and its Nurse-Midwifery program, both badly needed mid-level practitioners.

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In addition, the Dental School will be sending students for urban rotations, and conducting a postgraduate program in primary care dentistry with five residents in each year. Also, Consumer Health Education, Nutrition, and Continuing Education coordinators will be implementing programs to promote health and improve the quality of care rendered. In addition, we will be establishing primary care residencies in family practice with six residents in each year for a total of eighteen residents who will bring badly needed primary care manpower to the area. We are also planning innovative minority recruitment programs into the health professions from the community populations and a possible health administration program. In addition, we will be providing medical, dental and other health professional students with learning experiences which will help them bridge the cultural barriers to rendering effective health care to minority populations in this community. All of this is occurring in the Camden AHECs as a result of affiliations between four schools in the College of Medicine and Dentistry of New Jersey, and three hospitals in the City of Camden in addition to the Camden County Health Department, all subcontractors and partners in the New Jersey AHEC Program.

In Connecticut, another urban example is the Hartford AHEC Program with the contractor The University of Connecticut. In Hartford there are two very important components of the program; professional education and consumer education. The problem in Hartford is characterized by the fact that the city has a significant amount of health manpower, i.e. they are resource rich but they have some of the worst health status indicators. The gap between resources and high incidence of morbidity and mortality as they have diagnosed it is less a problem of getting people there and more a problem of making the resources there more effective, i.e. changing the behavior of both the providers and consumers. Toward this end, Hartford has devised some unique plans. For their professional students and providers, they are developing curricula and training experiences that will place the health professionals out with neighborhood health teams, visiting nurses, etc. into the community so that they will be able to reach into the community and improve its health status. Towards this end, they will have undergraduate medical students, dental students and allied health students in addition to postgraduate physicians learning how to treat the populations in urban innercities. The second component concerns consumer change and is one of the more innovative approaches so far developed in urban AHECs. The University of Connecticut is developing and will test community health teams that will attempt to change the ways consumers use their health resources. These health teams will both educate and advocate for the community, most directly for the ten thousand people they represent. They will be advocating and developing screening activities, health fairs, health careers approaches, health centers, nutritional changes, life style changes, risk decreases, etc. These teams are early in the test stage and have already had some notable success.

In Pennsylvania, the University of Pittsburgh is presently developing an urban AHEC Program that will place medical, dental, nursing and a number of other students out of the academic health center and into neighborhood health centers and family practice residencies throughout the urban innercity of Pittsburgh. They are presently projecting that 135 medical students will have experiences in primary care family practice in the innercity among different populations and in different settings as a result of AHECs as opposed to only 15 who had these experiences in family practice before. Also, AHEC has the responsibility for the support of six family practice residencies and is now developing a very close interaction between the medical school and the community in which the community has greater input into the way the school makes its decisions. In nursing it has increased the numbers of nursing students trained as family practitioners and is now increasing the number of continuing education courses for practicing nurses in the innercity. In dentistry, as well as in other health related professions such as nutrition, physical therapy, dietetics, etc., it is increasing the number of students having experiences outside the university and in the innercity which is both providing new educational programs as well as helping solve service problems. In Pittsburg, the numbers of health manpower is not as much a problem in this area, as are the poor health status indicators. The universities' approach in Pittsburgh is to move students cut of the health centers into primary care settings in the innercity and to develop ways to improve the quality of care that is being rendered and improve the health of its residents.

In California, Los Angeles provides a good example of a complicated urban AHEC in its very earliest planning stages. Los Angeles has many of the problems common to health care in innercities. The issue here is more of how to get health manpower resources functioning in the most disadvantaged areas. The California program is presently planning four AHECs in the Los Angeles area; with USC in the East San Gabriel area which has large Mexican-American concentrations, in Watts with DREW Medical School, in the LA basin in Ventura and Antelope Valley, and in Orange County where there are large Asian and Vietnamese concentrations. Student rotations and educational programs of numerous types are in the very early planning stages that will attempt to address the needs of this innercity.

In Summary, nine states now have AHEC programs in a number of urban areas. This movement of AHECs into urban central cities has occurred since 1977 at the urging of both the House and Senate. Most of the urban AHECs are in the planning and development stage, and are preparing to implement many of the strategies that have been successful in rural AHECs. In addition, urban AHECs are developing new approaches and strategies to address the health manpower and delivery system problems which are unique to urban central cities. Generally, urban AHEC programs are responding forcefully and ingeniously to improve the supply, distribution, quality, utilization, and efficiency of health manpower in the health care delivery system in central cities and ultimately improve the health of the residents in these areas.

Mr. **WAXMAN**. Thank you very much. I appreciate the perspectives each of you have given on the AHEC program.

I would like to recognize our colleague, Congressman Preyer. He is chairman of another subcommittee that is unfortunately meeting at the same time but he has a particular interest in this area. I would like him to proceed first with the questions.

Mr. **PREYER**. Thank you, Mr. Chairman. I appreciate the courtesy. I welcome all of the panel here. I hope you will forgive me if I take special pride in Dr. Mayer who has done an outstanding job in our AHEC program in North Carolina.

We are interested in whether the AHEC actually does have a practical effect on improving distribution of physicians. I wonder if you could tell us a little bit about how, if at all, it has improved distribution of physicians in North Carolina?

Is there a link between AHEC and that improved distribution?

Dr. **MAYER**. Thank you, Mr. Preyer.

We know there has been a major change in the distribution of physicians in our State. We think we have had something to do with it as well as many of the other initiatives that the Federal and State governments and communities have put on to attract and retain doctors.

We have a relatively simple map which shows the pattern of physician distribution in our State over three different time periods. [See p. 673.] We have 100 counties. From 1960 and 1964 nearly half of our counties were showing an improvement in the physician population ratio during that 4-year period of time.

From 1964 to 1970 only 22 of our counties showed improvement and that was the period of the latter part of the 1960's when there was great attention and concern given to the question of physician distribution. Our State became particularly concerned over these data. Fifty-one of our counties from 1964 to 1970 were showing a worsening.

For the period 1970 and 1977 we have had a complete turnaround in the distribution with 80 of our 100 counties showing an improvement in the physician population ration with only 6 showing a worsening.

The important thing about these data is they are not limited to the east or the west or the central part of our State. It is clearly a statewide phenomena. When one factors out the rural counties, which most of ours are, and then compares them with comparably matched samples of rural counties from around the Nation in those States that do not have AHEC's you will find something like a 17-percent improvement in our rural counties in terms of physician population ratios relative to only 2 or 3 percent for the national sample.

We can demonstrate there has been change and improvement on a statewide basis. How does one link this to AHEC's? That is much more elusive particularly when one has the National Health Service Corps; Office of Rural Health Services; HEAL program; RHI's, and lots of important community efforts to attract doctors.

We survey physicians who come to our State each year and ask them lots of questions about why they chose the town they chose to practice in. We have seen the answers to a series of questions which link their presence in that town to the nearby presence of residency training or student activities.

When we asked this question over time we found in 1972 something like 4 percent of physicians who settled in our State that year and their choice was in some way related to the presence of the educational process nearby.

In 1978 it was about 52 percent that said they settled in large measure because of the presence of the educational process. There are lots of other factors. AHEC is one which we think is of some importance.

Mr. **Preyer**. Thank you.

What has been the support of organized medicine for AHEC program in North Carolina and nationally?

Dr. **Mayer**. I think nationally it has been extremely good. Certainly in our State it has been excellent. We make it very clear that we do not develop programs such as residency training programs unless we have the full support of the medical staff in that community.

We sit on most of the major medical society committees. I am president of our county medical society which is the largest society in the State. Our interrelationships have been superb and the kind of support we get from organized medicine could not be better.

Mr. **Preyer**. The relationship between the Rural Health Service and the National Health Service Corps on AHEC's has been pretty good?

Dr. **Mayer**. It has been good but there is a problem that flows at least out of the rules and regulations that were written relative to the 1976 act.

We are basically an education and training program. We are not really a service delivery program except insofar as one sees patients in order to do teaching.

Some of the rules and regulations would have us taking on service relationships to the National Health Service Corps like covering their offices when they go on vacation. We cannot do that.

As long as our relationship to the National Health Service Corps is kept to educational support services, which we would like to see the statute reflect, then we can do a very effective job of working together.

I think we all have examples which we could share with you to prove these kind of interrelationships have already developed in many areas.

Mr. **Preyer**. Why should the Federal Government continue to provide even modest funding beyond the original agreement?

Dr. **Mayer**. For the 10 original projects such as ours?

Mr. **Preyer**. Yes.

Dr. **Mayer**. We recognize we have been treated very fairly by the Federal Government in terms of AHEC funding. We also recognize the commitment from Congress and HEW has been to fund the original projects through 9 years. That promise has been lived up to by the Government and we appreciate it.

We do think we have now put into place in at least the 10 States interrelated systems of education that link the university with community hospitals and through them to smaller towns in which the Federal Government should have pride in and for which it should continue to make demands of us in terms of program initiatives.

With that base in place and with some modest Federal funding relative to what we have received in the past, we think the Government could continue to have us serve initiatives that the Government thinks to be important.

We would expect we would have to meet the new statutory criteria of what AHEC's are and no longer be grandfathered from those criteria as we have been for the last couple of years and presumably these initiatives we would do could be linked to whatever you have in the special projects section of the health manpower bill.

We think the Government would get a lot for the limited amount of funds it would put into us if they would continue to give us some help.

Mr. **Preyer**. Thank you, Dr. Mayer. Thank you, Mr. Chairman, for letting me proceed out of order.

Mr. **Waxman**. Thank you, Mr. Preyer.

Dr. Carter?

Mr. **Carter**. Thank you, Mr. Chairman.

Would you contrast your training program, its curriculum and its clinical work with that of the traditional medical education model?

Dr. **Mayer**. Dr. Watts?

Dr. **Watts**. I think the fundamental curriculum remains the same as it was when I went to medical school and when you went to medical school with some modern additions to it in terms of more science and more flexibility.

I think the flexibility component is important as far as the AHEC programs are concerned because in many of our schools there are now many free or elective periods during the educational process. This has provided the students many of whom have an interest in family practice and in practicing in underserved medical areas an opportunity through the AHEC to take preceptorships or clinical clerkships in these underserved areas.

In California we are now able to show students who have taken these preceptorships in the underserved areas and the clerkships do apply for residencies in the family practice programs. We are just beginning to show when they get through their resiencies a substantial percent like 70 or 80 percent of them remain in the underserved areas.

Mr. **Carter**. I believe you stated that 70 percent of those who were in the AHEC program in Illinois remained in rural areas.

Dr. **Watts**. It may be the same everywhere. I was speaking for California.

Mr. **Carter**. What role does the community play in assuring the effective operation of your program?

Dr. **Mayer**. The one in North Carolina?

Mr. **Carter**. Yes, sir.

Dr. **Mayer**. A very important role. Each of the AHEC's is grounded in a community corporation. I believe that is true nationally. The character of those corporations will vary from State to State.

Ours in North Carolina has a heavy preponderance of hospital administrators, hospital trustees from the major institutions, physicians, and others.

In addition to the corporate structure we have a variety of advisory committees. Each of our AHEC's are designed to serve a particular set of counties so that all counties in the State fit into one of the AHEC's. All of our advisory committees are reflective of all types of health manpower from physical therapists to occupational therapists to physicians and each of the counties that are deserved. I think that pattern is basically repeated around the country.

Mr. **Carter**. What part of the resident's time is spent in a rural setting?

Dr. **Mayer**. That varies from program to program. It is also dependent a bit on the rules of the accrediting bodies that look at the residency programs. They have strict rules about how much time can be spent away from the home base.

For our family practice residents I believe we do something like 2 months in the second and third years of residency out in smaller communities.

Mr. **Carter**. In this case does your resident receive the advice of another physician who has completed his training?

Dr. **Mayer**. Yes, sir.

Mr. **Carter**. Have you established routes of referral for difficult cases?

Dr. **Mayer**. Absolutely. I think the point we would like to make was similar to Dr. Watts' point that all of our training programs are the responsibility ultimately of one of the four medical schools in our State and follow all of the quality and academic and accreditation considerations.

We are not a free standing academic unit. Our job is to help the traditional departments and the traditional schools do a job that puts them in greater contact with the community that they would otherwise do on their own.

Mr. **Carter**. Are there other practitioners, such as nurses and dentists in your program? Dr. Landay?

Dr. **Landay**. Yes, sir. In our particular program we have an allied health profession school that is involved with its multitude of allied health personnel. We have a dental school. We have two medical schools. We do not have a nursing school. Many AHEC programs do. There is a multitude of different types of health professionals in each program.

Mr. **Carter**. I believe you mentioned you have midwives in your area. Is that correct?

Dr. **Landay**. That is accurate.

Mr. **Carter**. Do you remember who delivered Queen Victoria's children?

Dr. **Landay**. I do not, Dr. Carter.

Mr. **Carter**. They were delivered by a midwife.

What part of your program's cost is covered by the AHEC grant and how do you cover other costs of operating the program?

Dr. **Landay**. Ours is in the startup phase and not fully operational.

Dr. **Mayer**. In ours which is now 8 years old we have an annual operating budget of approximately $20 million for AHEC in North Carolina. Of that nearly $17 million is State funded and about $1 million is Federal and that is a declining Federal balance as according to the plan. We have about $2 million a year of local money supporting our program.

Dr. **Watts**. In California the Federal contract certainly does not cover the whole program. There is substantial support from the State for the family practice programs which are really the core of the existing AHEC in California. We call the central San Joaquin Valley and the north coast and central coast the existing AHEC because they are on an old contract. The statewide contract is on a new contract.

The costs are shared with the State through the family practice programs, the Song Brown Act as it is called operated by the California State Health Manpower Policy Commission. Many of the programs are partially supported by the hospitals in which the programs take place. Many of them are supported by the California State college system and the California community college system for example in the development of training programs for allied health personnel.

The continuing education programs for physicians and nurses and others are largely supported by the people who receive those programs; the physicians and the nurses and the other health professionals.

Mr. **Carter**. About what percent is the Federal contribution?

Dr. **Watts**. I would say it is about 30 percent.

Mr. **Carter**. How will proposition 13 or passage of the proposed income tax law in your State affect your AHEC program?

Dr. **Watts**. I think we all have some concern about that in California. For one thing it is not passed yet. For another I think we will survive.

Mr. **Carter**. Thank you very kindly and I trust you will.

Mr. **Waxman**. Thank you, Dr. Carter. I hope so.

I understand that over the past several years there have been many applications for AHEC projects.

How many schools are currently interested in developing AHEC's?

Dr. **Mayer**. I do not know if we can answer that. I can tell you our experience has been to have many schools come and see what we are doing and to gain information. How many of those are actually interested in making applications, I do not know.

Mr. **Waxman**. Do you know how many AHEC's have actually been started since 1976?

Dr. **Mayer**. Twenty-two projects have been started. There originally were 11 and I believe there was a total of 22 at one time. Approximately 11 have been started since 1976.

Mr. **Waxman**. How many additional new starts do you think could be supported in the coming 3 years? Do you think many schools would do a good job?

Dr. **Mayer**. I have a personal concern concerning the opportunity for new projects. I would hope the Government does not go too fast in setting up too many and go beyond its own capacity to support them with staff and with advice.

I would think if the Government perhaps would start something like five projects a year that would be manageable. That is just a hunch.

Dr. **Watts**. In California with a statewide planning project, all eight schools have now indicated their interest in being cooperating schools. That means they are fully involved in all of the aspects of the program.

I think our concern is the interest in the program and the capability that we have to do things is going to outrun the support that we are able to get for the program. The interest in this has been far greater than I anticipated. All of the schools are enthusiastic.

The deans all met 2 weeks ago and have agreed to go ahead with it. It is agreed each school would start an AHEC next year and it is going to put a very severe limitation on [illegible] budget.

Mr. **Waxman**. Dr. Landay?

Dr. **Landay**. I do not have data but I have a strong feeling that a lot of universities would come forward and would like to have AHEC programs.

One indication I have in Mr. Carter's home State of Kentucky is the State is funding something called an AHES program. it is not federally supported at all. They are running it on State funds.

Mr. **Waxman**. Dr. Carter?

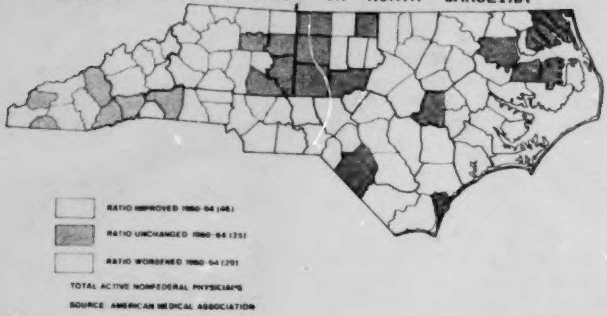
Mr. **Carter**. If the Chairman would yield, I think HEW has made a sad mistake in this area. We will see if they cannot correct it.

Thank you, Mr. Chairman.

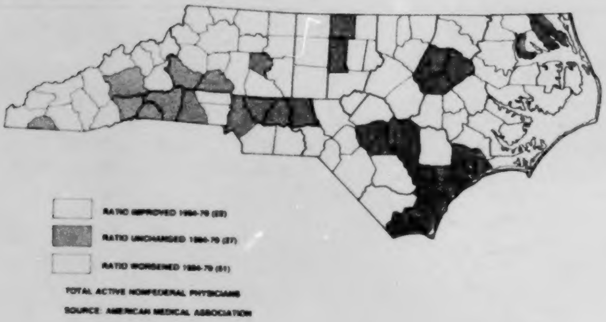
Mr. **Waxman**. Thank you. Gentlemen, we thank you very much for your testimony.

[The map referred to earlier follows:]

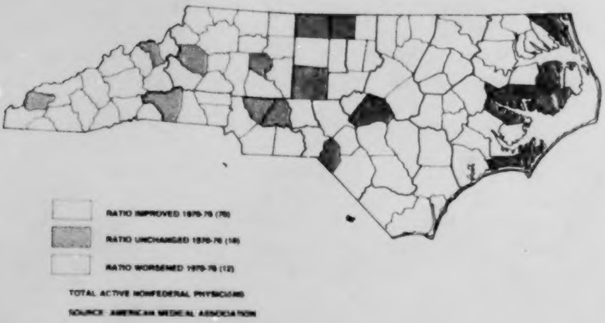
PHYSICIAN DISTRIBUTION IN NORTH CAROLINA


RATIO IMPROVED 1960-64 (46)
RATIO UNCHANGED 1960-64 (25)
RATIO WORSENED 1960-64 (29)
TOTAL ACTIVE NONFEDERAL PHYSICIANS
SOURCE: AMERICAN MEDICAL ASSOCIATION

NORTH CAROLINA • CHANGE IN POPULATION/PHYSICIAN RATIO BY AHEC REGION • 1960-1964


RATIO IMPROVED 1964-70 (22)
RATIO UNCHANGED 1964-70 (27)
RATIO WORSENED 1964-70 (51)
TOTAL ACTIVE NONFEDERAL PHYSICIANS
SOURCE: AMERICAN MEDICAL ASSOCIATION

NORTH CAROLINA • CHANGE IN POPULATION/PHYSICIAN RATIO BY AHEC REGION • 1964-1970


RATIO IMPROVED 1970-76 (70)
RATIO UNCHANGED 1970-76 (18)
RATIO WORSENED 1970-76 (12)
TOTAL ACTIVE NONFEDERAL PHYSICIANS
SOURCE: AMERICAN MEDICAL ASSOCIATION

NORTH CAROLINA • CHANGE IN POPULATION/PHYSICIAN RATIO BY AHEC REGION • 1970-1976

Mr. WAXMAN. I would like to call Ralph J. Van Brocklin from the American Student Dental Association. We are pleased to have you with us. We will make your statement part of the record. I would like you to summarize your statement if you would but you may proceed as you wish.

STATEMENT OF RALPH JAY VAN BROCKLIN, PRESIDENT AND BOARD CHAIRMAN, AMERICAN STUDENT DENTAL ASSOCIATION

Mr. VAN BROCKLIN. As stated, my name is Ralph Jay Van Brocklin. I am a third year student at the University of Pennsylvania School of Dental Medicine.

As president and chairman of the board of the American Student Dental Association I wish to thank you for the opportunity to present this testimony on behalf of our 17,000 members.

My statement due to time constraints will be limited to a discussion of the student assistance programs under the health manpower legislation.

[See p. 677.]

Today's students of dentistry find the path toward garnering their professional education beset with tremendous financial difficulty. Many students are already experiencing problems in arranging financing of their dental studies.

In a recent survey the American Association of Dental Schools found a 26-percent decrease in the number of dental school applicants between the 1975 and 1978 application cycles mainly from individuals whose families would be characterized as the socioeconomic lower middle class and postulate that much of this decline results from the inability to secure adequate loan an scholarship moneys to offset the immense costs of tuition and other expenses.

The rapid escalation of tuition costs seen throughout the educational community is especially apparent in dentistry. Tuition has climbed an average of 107 percent or slightly more than double in just 5 years.

The Fairleigh Dickinson University School of Dentistry has assessed a 237-percent increase since academic year 1973–74 including a 50-percent increase between the 1978–79 and 1979–80 school years.

The failure of an attemped suit against the school for such an exorbitant increase, *Joan Allen* v. *Fairleigh Dickinson University* this past year, further underscores the helplessness of the student when dealing with tuition increases. When they are levied the students really have no real recourse but to pay them.

Other schools showing large increases include Georgetown with a 224-percent increase over 6 years. New York University had an increase of 205 percent. The University of Pennsylvania had 173 percent increase. Columbia had 144 percent increase. Boston University had 134 percent increase. The University of Southern California has seen 126 percent increase in the last 6 years.

The availability of a source of readily accessible and affordable loan funds must be assured students if they are to be able to meet these wildly escalating tuition assessments.

Over 44 percent of the Nation's dental students pay in excess of $3,000 in tuition per year and 27 percent pay more than $6,000 yearly just in tuition. If tuitions, instruments and educational expenses and the cost of living continue to escalate at the overall average rates reported for the past 4 years the total expenditure to students at several institutions might approach $90,000 or more.

It should be readily apparent that until such a time as some stability can be imparted upon the rising costs of obtaining a dental education any specified annual and cumulative loan ceilings will become outdated almost as soon as they are enacted.

Complicating this forboding financial picture is the fact that the financial aid resources available to dental students are extremely limited.

Federal student loans are heavily relied upon by the dental student as a primary source of funding to meet the immediate cost of professional school.

For example in academic year 1978–79, 94 percent of all freshmen dental students attending NYU College of Dentistry received loan funds. Eighty-two percent at Georgetown and 75 percent at Harvard and 82 percent at the University of Southern California utilized Federal loan funds to partially or totally finance their education.

At the present time four Federal loan programs are available to meet students' needs: the health professions student loan program; the HEAL program; the GSL program and the NDSL program. Two of these programs, the health professions student loan and the HEAL programs are under the purview of this subcommittee.

The ASDA believes that any Federal student assistance programs resulting from the revision of the Health Manpower Act by this subcommittee should include certain basic provisions if the programs are to help alleviate the current crisis in financing dental education.

Specifically we recommend that annual and cumulative loan ceilings be set at a higher level or be removed entirely. Restrictions to prevent borrowing for nonacademic reasons should be similar to that currently incorporated into the health professions student loan program which sets an upward yearly limit of the cost of tuition plus a certain sum for other educational and living costs.

Two, the inschool interest subsidy provisions of the HPSL be included in all future loan programs. This allows all capital borrowed to go to the immediate costs of the student's education and prevents the insurmountable debt loads resulting from deferred interest payments.

Although the American Student Dental Association recognizes that this is a costly feature to any loan program the ASDA believes that it will help to keep the cost of dental services from rapidly escalating. It is an unfortunate fact that any massive increases in the cost of obtaining a dental education will end up being passed on to the patients that the graduating student serves.

Three, reasonable interest rates similar to those used in the past be continued.

Four, provision be made for graduated repayment of the moneys borrowed in order to avoid overburdening the newly graduated student.

Five, loan forgiveness clauses be inserted for individuals who help alleviate the problems of access to care by opening a practice in an underserved area.

Six, the scholarship program for exceptionally needy students be expanded from a 1-year to a 4-year program.

The American Student Dental Association believes that adherence to these principles will continue to make health professional education a viable option for individuals of all socioeconomic backgrounds, an option which we feel has unfortunately begun to close recently.

Excessive terms and a paucity of money will have the effect of closing the professions to all but the select few whose families have sufficient wealth to help finance their son's or daughter's education.

Finally by keeping total indebtedness down loan programs incorporating these principles should allow students to continue to pursue less lucrative careers in reseach and academics. Similarly the option of serving in an underserved area remains viable if the student is not so far in debt that he or she must locate in an ecomonically more attractive area.

We thank you for this opportunity to present our recommendations.

[Testimony resumes on p. 684.]

[Mr. Van Brocklin's prepared statement follows:]

STATEMENT OF RALPH JAY VAN BROCKLIN, PRESIDENT AND BOARD CHAIRMAN, AMERICAN STUDENT DENTAL ASSOCIATION

Mr. Chairman and members of the Subcommittee on Health and the Environment:

My name is Ralph Jay Van Brocklin, and I am a third year student at the University of Pennsylvania School of Dental Medicine. As President and Chairman of the Board of the American Student Dental Association, I wish to thank you for the opportunity to present testimony on behalf of the ASDA's 17,000 members. My statement today will be limited to a discussion of the student assistance programs currently authorized under the health manpower legislation. The ASDA will submit a comprehensive written statement including our legislative recommendations on the many programs authorized under this legislation in the near future.

Todays students of dentistry find the path towards garnering their professional education beset with tremendous financial difficulty. Many students are already experiencing problems in arranging financing of their dental studies. In a recent survey, the American Association of Dental Schools found a 26.0% decrease in the number of dental school applicants between the 1975 and 1978 application cycles. They note that the most significant decline in applications came from individuals whose families would be characterized as the socio-economic lower middle class and postulate that much of this decline results from the inability to secure adequate loan and scholarship monies to offset the immense costs of tuition and other expenses.

The rapid escalation of tuition costs seen throughout the educational community is especially apparent in dentistry. Tuition has climbed an average of 107% , or slightly more than double, in the past five years. This average figure tends to mask the scope of the problem at some of the individual institutions. The Fairleigh Dickinson University School of Dentistry has assessed a 237% increase since academic year 1973-74, including a 50% increase between the 1978-79 and 1979-80 school years. The failure of an attempted suit against the school for such an exorbitant increase (Joan Allen vs. Fairleigh Dickinson University) further underscores the helplessness of the student when dealing with tuition increases. When they are levied, the students have no real recourse but to pay them.

The magnitude of the increase at Fairleigh Dickinson University is not unique. Georgetown University School of Dentistry has shown a 224% increase over the same time-span, followed by New York University (205%), The University of Pennsylvania (173%), Washington University at St. Louis (162%), Northwestern (148%), Columbia (144%), and Boston University (134%). The University of Southern California School of Dentistry has shown a 126% rise over the past six years, while the University of the Pacific has experienced a 124% increase over the past five years. The availability of a source of readily accessible, affordable loan funds must be assured students if they are to be able to meet these wildly escalating tuition assessments.

The total cost of obtaining an education at many of our schools of dentistry is astounding. Over 44% of the nation's dental students pay in excess of $3000 in tuition per year, and 27% pay greater than $6000 yearly. Adding the average figure of $2550 currently paid by first year students for instruments and books, and taking into account the costs of living, it is readily apparent the scope of the financial burden. At the University of Pennsylvania, first year students entering in September, 1979, faced educational costs of $16,400, of which tuition alone, amounted to $8600. Georgetown University, Tufts, New York University, and the University of the Pacific all approach $20,000 per year due to their higher tuitions. If tuitions, other educational expenses, and the cost of living continue to escalate at the overall average rates reported for the past four years, the total expenditure to students at these institutions might approach $90,000 or more. It should be readily apparent that until such a time as some stability can be imparted upon the rising costs of obtaining a dental education, any specified annual and cummulative loan ceilings will become outdated almost as soon as they are enacted.

Complicating this foreboding financial picture is the fact that the financial aid resources available to dental students are extremely limited. The ASDA's review of current grant support revealed only eight sources of direct aid for dental education, each of which bore some restrictions on eligibility. Although scholarships and grants are a viable funding option for students at other educational levels, a recent survey conducted jointly by the American Association of Dental Schools (AADS) and the American Dental Association revealed that less than 15 percent of the total funds raised by the 1978 dental school graduates surveyed was provided by scholarships and grants. Less than 2 percent of the dental students who graduated in 1979 received financial aid through the National Health Service Corps Scholarship Program. These figures indicate that this program is not really an effective program of student assistance for our nation's dental students. In addition, it must be remembered that Armed Forces Scholarships are no longer offered to dental students. To further complicate matters, many dental schools have meager endowments for student aid, since per capita contributions from dental alumni are among the lowest of all professional schools within a university. Less than 13 percent of this year's freshman class receives scholarship or grant aid from the dental school or parent university.

These factors all contribute to the current situation where federal student loans are heavily relied upon by the dental student as the primary source of funding to meet the immediate cost of professional school. In 1973, HEW reported that 64 percent of all dental students attending school in 1970-71 utilized loans to partially finance their education. In academic year 1978-79, 94% of all freshman dental students attending the New York University College of Dentistry received loan funds. Similar figures are noted at other dental schools. For example, 82% of the dental students at Georgetown University, 75% at the Harvard School of Dental Medicine, 80% at Creighton University, and 82% at the University of Southern California utilize federal loans to partially or totally finance their education.

At the present time, four Federal Student Loan Programs are available to meet dental student's needs; the Health Professions Student Loan Program (HPSL), the Health Education Assistance Loan Program (HEAL), the Guaranteed Student Loan Program (GSL), and the National Direct Student Loan Program

(NDSL). Two of these programs, the HPSL and HEAL programs, are under the purview of this Subcommittee.

An examination of the financing patterns of the dental students from the class that will graduate in 1982 illustrates the relative importance of these loan programs. Twenty-seven percent of these students received funds under the HPSL, 5 percent borrowed under HEAL, 61 percent utilized the GSL and 22 percent received loans under the NDSL. It must be borne in mind that the rather low percentage utilization of the NDSL and HPSL is due to their unavailability at many of the dental schools, and not due to a lack of need for these particular sources of funding. The 61% utilization of the GSL would likely be higher if many students had not already reached the loan ceiling on this program as undergraduates and the low use of the HEAL Program is understandable due to its more expensive terms and lack of federal interest subsidy. Even if the educational costs of the class graduating in 1982 were to remain static at the 1979-80 rate, many of these students would not be able to obtain sufficient funding through these four programs, as they currently exist, to complete their education. This is due to annual and cumulative lending ceilings that are too low, the lack of availability cited earlier, and the failure to appropriate at the levels authorized. Mutual exclusivity of loan programs compounds the problem.

The ASDA believes that any federal student assistance programs resulting from the revision of the Health Manpower Act by this Subcommittee should include certain basic provisions if the programs are to help alleviate the current crisis in financing dental education. Specifically, we recommend that:

1. Annual and cumulative loan ceilings be set at a higher level, or be removed entirely. Restrictions to prevent borrowing for non-academic reasons should be similar to that currently incorporated into the Health Professions Student Loan Program, which sets an upward yearly limit of the cost of tuition plus a certain sum for other educational and living costs.

2. The in-school interest subsidy provisions of the HPSL be included in all future loan programs. This allows all capital borrowed to go to the immediate costs of the student's education, and prevents the insurmountable debt-loads resulting from deferred interest payments.

Although we recognize that this is a costly feature to any loan program, the ASDA believes that it will help to keep the cost of dental services from rapidly escalating. It is an unfortunate fact that any massive increases in the cost of obtaining a dental education will end up being passed on to the patients that the graduating student serves.

3. Reasonable interest rates similar to those used in the past be continued.

4. Provision be made for graduated repayment of the monies borrowed, in order to avoid overburdening the newly-graduated student.

5. Loan "forgivedness" clauses be inserted for individuals who help alleviate the problems of access to care by opening a practice in an underserved area.

6. The scholarship program for exceptionally needy students be expanded from a 1-year to a 4-year program.

The ASDA believes that adherence to these principles will continue to make health professional education a viable option for individuals of all socio-economic backgrounds, an option which we feel has, unfortunately, begun to close recently. Excessive terms and a paucity of money will have the effect of closing the professions to all but the select few whose families have sufficient wealth to help finance their son's or daughter's education.

Finally, by keeping total indebtedness down, loan programs incorporating these principles should allow students to continue to pursue less lucrative careers in research and academics. Similarly, the option of serving in an underserved area remains viable if the student is not so far in debt that he or she must locate in an economically more attractive area.

The American Student Dental Association sincerely appreciates this opportunity to present our recommendations.

Mr. **Waxman**. Thank you very much for your testimony and your recommendations. I am very sympathetic to the points you raised.

Let me ask you why so few dental students take scholarship money and commit themselves to the National Health Service Corps?

Mr. **Van Brocklin**. These scholarship moneys really are not very available to dental students. About 2 percent of the dental students take them and that is roughly what we are allotted through the scholarship program.

I think there is a need for more moneys of this sort. I think you will find there are quite a few students who would go into that kind of program if the moneys were available.

I am not fully convinced that the National Health Service Corps is the ultimate answer to the access to care problem. There are some things starting right now and I do not know if you are aware of the National Health Professions Placement Network. It is a computerized service that started in Minnesota.

That service has managed to eliminate all but one of the underserved areas in the State of Minnesota. It has recently been expanded to a national program jointly funded by the American Dental Association and the W. K. Kellogg Foundation. We are very hopeful this will be able to get more dentists and eventually physicians into areas where they are needed.

Mr. **Waxman**. Does this service indicate areas where there is a need for physicians and dentists?

Mr. **Van Brocklin**. Presently it is just for dentists. They are using basically right now the areas that are ascertained by the National Health Service Corps to be shortage areas.

Mr. **Waxman**. It is solely the voluntary decision of the dentist to go to an underserved area after that?

Mr. **Van Brocklin**. Yes. What this does basically is it provides information as to the availability of these communities. Unless students go through the National Health Service Corps I do not think a lot of students are aware of where these opportunities are available.

The National Health Professions Placement Network provides information about the community; what the overall size is; what the community is like; how close it is to major centers and things of this sort. This is all very useful information to a student who may wish to practice in an underserved area but might be a little selective about which area he would care to go into.

Mr. **Waxman**. Would it also give information about whether an area would sustain a private practice or not?

Mr. **Van Brocklin**. No. That kind of information is not presently available. That is something that the individual who wishes to locate has to ascertain for himself. I believe there are plans to do that eventually. At this point the amount of money that has been put into the project is not sufficient to get that kind of information.

Mr. **Waxman**. Thank you. Dr. Carter?

Mr. **Carter**. Thank you, Mr. Chairman.

I am very pleased to see a young dental student here today. My only wish would be there be a medical student sitting beside you to testify as to the needs of that group as well.

What year of dentistry education are you in?

Mr. **Van Brocklin**. I am a third-year student, sir.

Mr. **Carter**. Have you ever done a spenopalatine block?

Mr. **Van Brocklin**. No, I have not.

Mr. **Carter**. A mandibular?

Mr. **Van Brocklin**. Plenty of those. The maxillary, we just do infiltrations.

Mr. **Carter**. I feel very sympathetic as to your financial situation. You state that at the University of Pennsylvania the cost per year would be about $16,400 per year.

Mr. **Van Brocklin**. Yes. That is for the entering freshman class this year. There is a slight discrepancy between what they are paying and the rest of us.

Mr. **Carter**. What percentage of dental students have to borrow?

Mr. **Van Brocklin**. It is better than 60 percent.

Mr. **Carter**. I believe it is 82 percent at Georgetown.

Mr. **Van Brocklin**. Yes. It varies quite a bit by school.

Mr. **Carter**. Under the HEAL program, I believe you pay 12 percent.

Mr. **Van Brocklin**. Yes.

Mr. **Carter**. For medical students, at the 12-percent interest rate, the total debt owed, with interest compounded, would be about $148,000 upon completion of training.

Mr. **Van Brocklin**. It depends with the HEAL program entirely on what you intend to do after your initial 4 years of training as to how much that will escalate.

The backgound work we did with this last year indicated if a dental student were to go through 4 years of regular training, borrow from the HEAL program all the way through and borrow at the maximum of $10,000 per year he would end up with a total indebtedness by the time the loan was paid off of slightly better than $100,000.

The $140,000 to $180,000 figure rests upon say 3 years of postgraduate training.

Mr. **Carter**. As you know, the administration bill would remove the 12-percent ceiling on the HEAL program's interest rate and let it float upward. Yesterday, Treasury notes sold at 14.4 percent on the market. If it floats upward to the market rate, the interest rate would be in the neighborhood of 17.5 percent.

How would that interest rate affect young dental students?

Mr. **Van Brocklin**. On myself personally, I think a little bit of my background is in order. I come from a rural area in California. There are a number of small communities in that area that have real problems with access to care as far as physicians and dentist help.

I personally had hoped to go back into that particular area and locate. As it is right now with an educational debt of $45,000 by the time I graduate even at 7-percent simple interest and with the interest subsidy, I feel that is going to make it extremely difficult for me to go into that area.

I am still planning on doing it but I think it is going to be extremely difficult.

If the rates were to be raised to that amount especially without the inschool interest subsidy it would create a situation where anybody desiring to go into that kind of practice would have to go through the National Health Service Corps or would not be able to do it at all.

Mr. **Carter**. I regret very much that we have a man who is Chairman of the Federal Reserve Board who believes in the brotherhood of man, the fatherhood of God, the neighborhood of New York City and 20 percent interest!

How much do you estimate it would cost you to set up a dental practice including the necessary equipment?

Mr. **Van Brocklin**. For a teacher practice it is somewhere on the order of about $40,000. For a three-chair practice which is considered to be about the most efficient for one man working by himself is on the order of $60,000 to $70,000.

Mr. **Carter**. What is the average salary for a general dentist as compared to a specialist?

Mr. **Van Brocklin**. It varies as far as how long the individual has been out of school. For those dentists under age 30 it is slightly more than $20,000. In a national average for all dentists it is considered about $42,000 as of 1978.

Mr. **Carter**. Do you think this high-interest rate would tend to discourage some students from going to dental school?

Mr. **Van Brocklin**. I believe it would. I believe as I said earlier in my testimony with the survey by the American Association of Dental Schools indicating a large decline from the lower socioeconomic groups that we are already starting to see this.

Mr. **Carter**. I believe it would tend to encourage them to go into specialized, more lucrative fields, rather than become generalists.

Mr. **Van Brocklin**. I am not certain that would necessarily happen. I think it is possible.

Mr. **Carter**. You have made a very fine statement and it certainly has been a pleasure to hear from you.

Mr. **Van Brocklin**. Thank you very much.

Mr. **Waxman**. I also want to commend you for your statement and we appreciate your coming.

Mr. **Van Brocklin**. Thank you very much, sir.

Mr. **Waxman**. Our next witness is Richard J. Dowling who is executive director of the American Society of Allied Health Professions.

STATEMENT OF RICHARD J. DOWLING, EXECUTIVE DIRECTOR, AMERICAN SOCIETY OF ALLIED HEALTH PROFESSIONS

Mr. **Dowling**. Mr. Chairman and Dr. Carter, the American Society of Allied Health Professions is a national scientific and professional organization whose membership is composed of national professional associations; university and college allied health schools and programs; public and private clinical service facilities and individual members from virtually all of the allied health disciplines. Allied health is the emergency medical technician at the scene of an accident: it is the audiologist diagnosing and treating hearing disorders and the clinical laboratory and radiologic technology professional involved in a wide variety of testing setttings and procedures. It is the obstetrical assistant involved in acute care therapy and the speech pathologist or physical or occupational therapist concerned with long-term rehabilitation. Allied health also is the radiation therapist: the respiratory therapist and the dialysis technician involved with the instruments of health care. It is the nutritionist and health educator devoted to community health promotion and protection and the environmental engineer whose work relates to environmental health promotion and protection. It is the hospital administrator and the health planner involved in management of health systems. It is the biomedical engineer and the epidemiologist.

Mr. WAXMAN. Excuse me for interrupting. Dr. Carter has to leave and he wanted to make a comment.

Mr. CARTER. I just wanted to tell you that I do support you and want to help all I can.

Mr. DOWLING. We know that, sir. Thank you.

Allied health is also the toxicologist and researchers in virtually every other allied health discipline who devote their energies and attention to health related research and development.

In all, allied health comprises more than 60 percent of the Nation's health care work force—closer to two-thirds of that work force.

Federal support of allied health education began in 1966. During the first few years it was substantial. For the past several years is has been miniscule. Over the 14-year period since 1966, support for allied health manpower development has amounted to only 4 percent of all health professions manpower training support, which means that only one-twenty-fifth of the total Federal investment in health manpower training has gone to those professions which represent nearly two-thirds of the health care work force.

Over the better part of the past decade, none of this insubstantial support has been authorized for capitation assistance or construction support or even direct student aid. It has been used to improve the quality of allied health education. It has a not been used to increase numbers of allied health professionals.

Back in 1966, the rationale for Congress investment in the allied health manpower development area was threefold. First allied health could deliver more services in greater variety to more people, especially those in unserved and underserved areas of the country. Second, it could do so less expensively than could the traditional health care service deliverers. Third, it could offer both to the economically disadvantaged and to members of underrepresented ethnic minority groups greatly improved access to participation in the health care professions.

Allied Health has met and exceeded Congress expectations in these regards and, if properly supported, can continue to do so.

Recently in introducing its health manpower bill to this House, the administration enlisted these among its primary objectives—assure the availability of health professionals in unserved areas; increase minority participation in health professions and target Federal resources to promote such national priorities as cost containment. These are all objectives which allied health is designed to achieve and most willing and we think best able to address.

You will understand, I am sure, why we find it passing strange—and that is an extremely charitable characterization—why the administration in H.R. 6800 would repeal each and every of the extant sections of current health manpower law which relates expressly to allied health. We are not pleased by the administration's offering.

The subcommittee has been provided copies of the society's full statment. It is based primarily on the recommendations of two very recent reports. One is the product of the Federal Government's own Bureau of Health Manpower and the second, the product of a 2-year study by the W. K. Kellogg Foundation-supported National Commission on Allied Health Education. Both were written to assist Members of Congress and other health care policymakers in shaping the future of allied health. Both view allied health training and services as essential elements of the Nation's health care education and service delivery systems. Both see a major allied health support role for the Federal Government.

Based on these two reports, Mr. Chairman, our testimony responds to the allied health related authorizations of existing law and the proposals introduced by Senators Kennedy and Schweiker and by yourself.

In particular we are concerned with the current law's definition of the term "allied health." It is inappropriate. We think it is unnecessary.

Our other recommendations, on pages 15 through 23 of our statement, relate to the National Advisory Council on Health Professions Education; important data collection needs; areas for project support emphasis and the continuation of an authorization for training institutes in allied health—both of which your bill addresses; the critical need for an increased emphasis on ethnic minority group involvement in allied health training; the National Health Service Corps; the national priority initiatives contained in both the Schweiker and Kennedy bills and the filling of what the Government has called "significant national allied health shortages."

We applaud the special emphasis which your bill gives to the National Health Service Corps. We would ask a special emphasis be given to the corps related sections of the law. That is that allied health students should be among those to whom service corps scholarships are awarded.

Last year more than 1,100 scholarships were granted. Not one went to a student enrolled in a school of allied health. Interestingly, more than 100 went to podiatry students. Why not at least a few dieticians or some rehabilitation professionals or some environmental engineers? There may be extraordinary foot care problems in unserved and underserved areas of the country, but there are also health care problems which these other professionals can address and ought to be encouraged to address.

Thank you very much for your attention.

[Testimony resumes on p. 711.]

[Mr. Dowling's prepared statement follows:]

STATEMENT

OF

THE AMERICAN SOCIETY OF ALLIED HEALTH PROFESSIONS

by
Richard J. Dowling

I am Richard J. Dowling, Executive Director of the American Society of Allied Health Professions (ASAHP).

The Society is a national scientific and professional organization composed of three councils, each representing a different aspect of Society membership. Our Council of Educational Institutions is made up of Allied Health Schools and educational programs which offer Allied Health degrees ranging from the certificate (through the associate, baccalaureate and master's degrees) to the doctorate. National professional associations and clinical service programs comprise the Society's Council of Professional Organizations. Our third council, the Council of Individual Members, is composed of clinicians, educators and administrators from all of the various Allied Health professions. Taken together, the Society's councils are as representative of Allied Health -- its strengths, its needs and its tremendous diversity — as is possible.

The Society is pleased to have been invited to offer its views on proposals to amend and extend present statutory authorities for federal support of health-manpower education, and I am honored to represent the Society's membership before this panel.

BHM and NCAHE Reports

Our testimony today is based, in significant part, on two reports dealing with manpower-training realities and needs in the Allied Health professions. The first of these is the product of the Health Resources Administration's Bureau of Health Manpower. Entitled A Report on Allied Health Personnel and released to the public only last week, it was prepared under the authority of section 702(d) of the Health Professions Educational Assistance Act of 1976 (P.L. 94-484), as amended, for the Senate's Labor and Human Resources Committee and the Committee on Interstate and Foreign Commerce of the House of Representatives.

The second report is the product of the National Commission on Allied Health Education, a blue-ribbon panel of health and education experts which, for a two-year period ending late last year, focused its talents and energies on the development of the Allied Health movement since the mid-sixties and on how that movement--still a relatively new force in our health care and health-manpower education systems--might best function in the decade of the eighties. Entitled The Future of Allied Health: Alliances for the 1980s, it will be published by Jossey-Bass, Inc. Publishers, in the next several weeks. The Society will be pleased to provide copies to Members of Congress and appropriate congressional staff members. The Commission's report, like that of the Bureau of Health Manpower, is intended principally as a reference book for policymakers whose decisions will affect Allied Health education and service delivery in the years ahead. The Commission was chaired by former University of Kentucky president Frank G. Dickey; its product and the two years of study and deliberation which preceded the report's completion were supported by the W.K. Kellogg Foundation of Battle Creek, Michigan.

The Allied Health Community

The Allied Health professions are heterogeneous in the extreme, differing in the competencies they require, their respective requisite educational preparation, the scientific foundations for their knowledge bases, and the clinical and educational roles which they play in the nation's health-care delivery system.

Required competencies vary from the performance of relatively routine tasks to the highest levels of education and service-delivery administration and the generation of new knowledge through research. Similarly broad is the range of educational preparation the Allied Health professions require--from limited post-secondary training to postdoctoral study. The time required for such preparation ranges from several months to more than a few years.

The scientific foundations of Allied Health profession expertise range from the biological and chemical sciences (e.g., clinical laboratory professionals) to the social sciences (e.g., social workers and clinical psychologists) to combinations of the physical and social sciences and the humanities (e.g., speech pathologists, rehabilitation counselors).

Some Allied Health professionals are involved primarily in institutional patient care, others in community health promotion and protection, still others in health-care research, manpower training, and education and service delivery administration. The range of Allied Health services includes:

- emergency services (e.g., emergency medical technicians, physician assistants);
- reception and screening (e.g., medical and dental secretaries, medical office assistants);
- initial evaluation and diagnosis (e.g., audiologists, physician assistants, dental hygienists, mental health technologists, medical social workers);
- continued assessment as part of treatment (e.g., physical therapists, occupational therapists, respiratory therapists, speech pathologists, audiologists, dietitians);
- testing (e.g., medical laboratory personnel, radiologic technologists, ultrasound technical specialists, nuclear medicine personnel, cardiology equipment personnel);
- acute care therapy (e.g., operating room technicians, obstetrical assistants, surgeons' assistants);
- long-term care therapy (e.g., occupational, physical and other therapists; personnel in mental health and social services, counseling, speech pathology, audiology, nutrition);
- medical instrumentation (e.g., radiation and respiratory therapists, dialysis technicians, cardiopulmonary technicians, opthalmic dispensers, dental laboratory technicians);
- community health promotion and protection (e.g., nutritionists, dental hygienists, population and family planning specialists, health educators, school health educators, medical librarians, health writers);
- environmental health promotion and protection (e.g., sanitarians, environmental health technicians, sanitarian aides, environmental engineering assistants);

- control and elimination of hazards in an institutional or industrial setting (e.g., audiologists, health physicists, health care facility housekeepers, industrial hygienists);
- health systems management (e.g., hospital administrators, health planners, medical records personnel, medical computer specialists);
- research and development (e.g., biomedical engineers, biostatisticians, epidemiologists, toxicologists, public health scientists, and researchers in every occupational category).

An essential feature of Allied Health education since the 1960s has been its rapid change and expansion, characterized by the following three major ingredients: First, there has been a tremendous growth in the number of programs, particularly in collegiate settings, which has paralleled the great expansion of two-year colleges and the growing popularity of vocational programs (in 1966, there were an estimated 2,500 collegiate programs; today there are over 8,000); second, the distribution of programs has changed--hospitals and other health-service settings still play an important role, but the greatest program growth has occurred in such other settings as medical centers and universities, two-year colleges, vocational technical institutes, and private career schools; third, a dramatic expansion of knowledge and skill requirements has led to increased diversification of educational requirements.

In 1976, the latest year for which there is adequate survey information, there were about 14,000 formal postsecondary programs for Allied Health personnel. Of these,

- 52 to 54 percent were in collegiate settings,
- 33 to 35 percent were in hospitals,
- 10 to 12 percent were in postsecondary non-collegiate institutions, and
- one percent were in the armed forces.

Over half of the nation's 3,000 higher education institutions have at least one Allied Health program. Such programs are contained in about 90 percent of the nation's research universities and doctoral-granting institutions, as well as in large proportions of comprehensive colleges and universities, free-standing medical centers, and two-year colleges. Significantly more than half of all Allied Health programs in collegiate institutions award degrees at the baccalaureate or higher level.

It may be important to point out here that these patterns of education for the Allied Health professions have grown out of practice needs, rather than from abstractly determined sets of values. Thus, the history of Allied Health education, brief as it is, is closely related to the history of the occupations themselves. The burgeoning of the Allied Health professions and of Allied Health education is the product of increased and increasing health-service demands and the explosive growth in health science and technology.

Manpower data is not what it might be-- what we hope it can and will be-- in the area of Allied Health. Still, we can say with reasonable assurance that, as of 1978, an estimated 3.5 million individuals (nearly 66 percent of the total health-care work force) could be classified, in the broadest sense, as Allied Health practitioners. The core of this population--the professions in which the federal government has invested the bulk of its Allied Health manpower-training funds and which, generally, require collegiate preparation ranging from the associate degree to the doctorate--has grown from 442,000 in 1966 to approximately 1,026,000 in 1978. This 132-percent rate of growth compares with a 76-percent growth rate for all health professionals.

Yet despite this growth, HRA's Bureau of Health Manpower tells us that there are still clear and significant national Allied Health manpower shortages in such professions as audiology, speech pathology and respiratory therapy. And though the data is not definitive, it also appears to the Bureau that there still may be national shortages of dietitians and dietetic technicians, radiation therapists, physical therapists, occupational therapists, and formally-trained dental assistants.

The Bureau goes on to report that, even in professions in which the overall national supply appears to be adequate, local or transitory shortages continue and employers across the country encounter difficulties in filling "critical Allied Health positions", requiring highly qualified professionals and exceptional skills.

Federal Support of Allied Health Education

Federal support for Allied Health manpower training was first authorized in 1966 by the Allied Health Professions Personnel Training Act. During the first four years of operation under its authorities, the statute put primary emphasis on increasing the number of training programs and professionals. In the early seventies, however, the statute was amended. its emphasis shifted: Basic improvement grants, which encouraged the establishment of new scholastic programs, were abandoned in favor of new focuses and initiatives, relating more to the provision of quality Allied Health education and health service than to the production of increased numbers of Allied Health professionals. The shift clearly was occasioned by public economic policy, and not by evidence that manpower needs had been met--there were at least as many "significant" national professional-area shortages at the start of the seventies as there are today.

The new funding focuses were on special educational projects for Allied Health training programs (interestingly,one special project focus addressed the need for the "establishment of new roles and functions for Allied Health" personnel), on faculty development through a mechanism called "advanced traineeships", and on the recruitment to the Allied Health professions and retention of ethnic minority-group members.

Funding authorizations which followed the shift from the early basic improvement grants to the special target grants and contracts were moderate, to say the most. But this moderate support soon became virtually no support at all. In fiscal year 1973, for example, Congress provided $30.2 million to support Allied Health planning, development and operation of such (sections 796,797 and 798) projects as the establishment of regional systems for coordinating and managing Allied Health training; of new and improved methods of credentialing Allied Health Personnel; of recruitment, training and retraining programs; of career ladders and other programs of advancement; of continuing education programs; of faculty training institutes; and of ethnic minority-group member recruitment. Last year, following an Administration call for zero funding of Allied Health manpower-training programs and projects, the Allied Health community was able to win congressional support for a $10 million fiscal 1980 appropriation for these Part G (Title VII) initiatives. This year, the Administration is calling not only for a zero funding level for fiscal 1981, it also is recommending that the monies appropriated for the present fiscal year should be rescinded.

The Administration's rationale for these zero-funding recommendations makes no sense at all. Administration spokesmen list cost effectiveness, the delivery of services to unserved and underserved areas of the country, disease prevention and health promotion, and the involvement of ethnic minority-group members in health-care education and service delivery as the major national health-care objectives. Yet, in what seems the same breath (expelled through the other side of its mouth), the Administration urges Congress to refuse any support for that segment of the health manpower population which is best prepared and best able to address these objectives.

In another jump off the cliff of logic, the Administration argues that, inasmuch as there are no manpower shortages among the Allied Health professions, "continued federal involvement in basic Allied Health training support" is unwarranted. The argument both denies and defies the reality of the Report of the Administration's own health-manpower agency, which not only makes a "case for continued Federal activity on behalf of allied health personnel," but also lists a relatively large number of key Allied Health professions in which there are "significant national shortages." But more--the Administration also seems to have overlooked the fact that federal Allied Health manpower-training funding is expressly intended by statute for special-target projects and not for basic education support. Indeed, such basic support hasn't been available to the Allied Health professions for the better part of a decade!

Some might argue that the $276 million invested by the federal government (since 1967) in Allied Health manpower training is not only a substantial amount, but an appropriate amount as well. Substantial it well might be; appropriate it most assuredly is not. The $276 million figure-- the federal government's total 14-year commitment to two-thirds of the nation's health-care workforce--represents merely four percent of the total federal investment in health-manpower training and development. From its beginnings, Allied Health has been relegated by the federal government to but a cubby hole in the great mansion of health-care education. Today, there's an eviction notice on our small door. We hope this Subcommittee will tear down that notice and, in doing so, give notice of its own that Allied Health can, must and will be counted on by the federal government as a major partner in the development of an effective manpower-training and service-delivery effort.

Bureau of Health Manpower Recommendations

The Society believes that the federal government must assume a leadership role in helping fill what HRA's Bureau of Health Manpower terms as "significant national [Allied Health] shortages."

In addition, we see a major federal responsibility in the fulfillment of these of the Bureau's Allied Health related recommendations:

1. "Information including statistical data on allied health personnel requires continued improvement, by larger investments and coordinated activities...

"Particularly, data are needed with which to determine the nature and extent of 'critical vacancies' and specific skills shortages, and to plan appropriate local, State, regional, or national remedies.

"More data are needed to evaluate the effects of governmental and private sector regulation upon personnel utilization, health care costs, quality of service, and demands for continuing education.

"Better data are needed on minority participation in the work force.

2. "Special attention to the allied health personnel problems of small health care institutions is required, to ensure that regulatory and other constraints do not interfere with access to and the quality and continuity of patient care. Additional resources are needed with which to investigate the nature, extent, and impact of these problems, and to devise solutions as may be necessary.

3. "The cost-saving potential of more efficient use of allied health personnel should be thoroughly explored through well-designed and controlled studies carried out in various work settings and not hindered by current legal limitations on the use of personnel.

4. "As personnel standards are changed, training programs must be revised. This requires national coordination and encouragement.

5. "As manpower standards change, personnel working in the field who cannot meet new and more rigorous qualifications must be provided with opportunities to improve their competencies. Support to develop training materials and procedures that will reach the employed work force is necessary.

6. "Methods of testing of individuals to determine competency in the health field require improvement, through additional research, development, and validation, with Federal leadership.

7. "To the extent necessary to ensure adequate numbers of these personnel equitably distributed among and within States, Federal programs must encourage comprehensive State programs to identify and act upon problems of maldistribution and undersupply.

8. "There should be established within the Department (i.e. HEW) the function of review and approval of all Federal policies and actions that lead to or encourage new health occupations or specialties.

9. "There should be established within the Department the function of review and assessment of all Federal policies and regulations that affect the demand for or utilization of health personnel.

10. "Improvement of specific clinical competencies of allied

health personnel is required, through advanced and short-term training and through self-instruction, particularly for the following subjects or functions:

- long-term care of the elderly and chronically ill,
- hospice care,
- disease prevention and health promotion, and
- application of new technologies.

11. "Improvement in nonclinical competencies of allied health personnel is required, through advanced and short-term training and through self-instruction, particularly in:
    - teaching
    - educational program planning,
    - administration and supervision, and
    - performance evaluation and assessment.
12. "Maintenance and further development of allied health training centers should be encouraged so that they carry out essential interdisciplinary coordinating and planning activities.
13. "Additional allied health training centers in institutions with predominantly minority enrollments should be established.
14. "Activities for the recruitment of and assistance to minority students in allied health training programs should be increased.
15. "The MEDIHC program (Military Experience Directed Into Health Careers) to place veterans and other allied health personnel in critical vacancies, especially in small and rural institutions, should be continued.
16. "Statewide and educational system wide planning for allied health occupations education and training, through grants and cooperative agreements, should be encouraged and supported.

Recommendations of the National Commission on Allied Health Education

The report of the Kellogg Foundation-supported National Commission on Allied Health Education is summarized in the brochure which I have attached to copies of my statement, and which I hope can be included as a supplement to my testimony in the record of this proceeding. As you and other readers of the record will note, the Commission lists 15 "primary recommendations" which it views as crucial to the future of Allied Health education and service delivery. The most critical of these 15, in our view, is the last, which offers that "Significantly increased funding for allied health should be provided at the federal, state and local government levels, and from private resources." Absent the recommended increase, the achievement of any of the remaining 14 primary Commission recommendations is impossible.

In addition to its primary urgings, the Commission offers 63 "procedural recommendations"-- proposed priority-action initiatives designed to implement the more general primary recommendations. Listed below are those of the procedural priorities which the Commission views as responsibilities of the federal government:

> Priority #1-- Link education to practice and end unnecessary expansion of entry-level requirements. Today, a gap exists between declaration and attainment of the goal of relating education to performance objectives based on health service demands. Current knowledge of practice needs is limited for most Allied Health professions. Consequently, educational content is determined by expert judgement and the tendency to err in favor of too much rather than too little education.
>
> - The federal government should support role-delineation projects and activities which lead to the more effective use of role delineations (e.g., workshops to develop a common methodology of role delineation so that results can be compared accross professions and commonalities in function and knowledge requirements can be identified).
> - The federal government should support projects to improve the methodology of performance-based testing, which can be used to provide alternate routes to certification (i.e., other than formal education) and to base the right to practice on demonstrated competency.
>
> Priority #2-- Assure flexibility of health professionals. In a rapidly changing health service delivery system, adaptability is essential. A broad foundation is particularly important in professional areas requiring lengthy preparation Flexibility may be developed through the acquisition of a knowledge base that is generic to health occupations, or of the competencies required to perform in more than one occupational role. Today, few educational programs provide students with preparation of this kind.
>
> - The federal government should support projects to design and implement curriculum modules based on role delineations for two or more occupations.

- The federal government also should support activities for sharing information and experiences of programs which currently prepare students for more than one occupational role.

Priority #3-- Include new subject matter designed to meet new service demands. Trends in health service and changing health priorities indicate the need to include subject areas which are not now a standard part of most Allied Health curricula: Human values, prevention of illness and promotion of health, and health-service delivery systems (roles and functions of health personnel, legal risks, patients' rights, cost effectiveness, and quality control). New instructional materials are needed in these areas for the various levels of health professions preparation.

- The federal government should support projects to develop and disseminate interdisciplinary instructional modules in human values, the prevention of illness, the promotion of health, and health-service delivery systems. The trial implementation of modules also should be encouraged.

Priority #4-- End unnecessary proliferation of new occupations and programs. The current tendency to create new occupations to meet each newly identified health-service need or each new health-service technology is wasteful and results in the increased splintering of health-service functions, impairment of health-service quality, and increased health-service delivery costs. Educational programs have virtually no financial incentives to seek alternative ways to meet new health-service needs.

- The federal government should support projects designed to demonstrate ways to meet new health-service needs without creating new specialties, such as:

  -- short-term supplemental preparation for existing health personnel,

  -- short-term preparation in health applications for college graduates who majored in relevant nonhealth fields (e.g., social services, education),

  -- inservice training programs for persons employed in nonhealth occupations who have contact with the patient/client population, and

  -- incorporation of new objectives in existing programs.

Priority #5-- Assure continuing competency of health personnel. Although there has been an explosion of activity in the area of continuing education, information on continuing education in Allied Health has never been compiled systematically, in a way which will facilitate cross-occupational exchange.

Many outstanding issues remain to be resolved (e.g., needs assessment, quality assurance, financing). A forum for collaborative problem-solving is needed.

- The federal government should support the establishment of a National Coalition for Continuing Education to provide leadership at national, regional, and local levels. This voluntary coalition would be a forum for collective problem solving, information-sharing, and research; it would facilitate, rather than regulate educational processes. Participants would represent all groups concerned with continuing education (e.g., educational institutions, professional associations, practitioners, employers, and accrediting, certifying, and licensing bodies).

Priority #6-- Integrate clinical and didactic education and expand the range of clinical education methods. It is essential that clinical education be viewed as part of the total experience in preparing personnel for the Allied Health professions. Today, however, students are often left to their own devices in obtaining and pursuing clinical learning experiences, and there is no assurance that the quality and range of clinical experience adequately complement the didactic experience. Further development of clinical education materials which can be used in a classroom setting is needed to increase student opportunities for translating theory into practice at all stages of a training program; such materials would both enhance and expand practical learning acquired in actual practice settings.

- The federal government should support the development and demonstration of alternative methods of learning for clinical competence (such as simulated clinical learning programs and programmed laboratory experiences), which are designed to better integrate clinical practice into the total educational experience and to ensure clinical competency in a period of decreasing educational program access to hospitals and other clinical facilities.

- Support also should be made available for intensive research on methods of clinical education which are designed to identify the types of professional learning most dependent on practical experiences and to ensure that the clinical education relates to a wide variety of practice needs.

Priority #7-- Improve articulation in Allied Health education. Continuity between various educational levels and study disciplines benefits both society at large and the consumer of educational programs. It is cost effective to include in each phase of education only those aspects of required learning that have not already been attained; it is wasteful to pay for the unnecessary repetition of learning experiences. In spite of a national trend toward more flexible admissions and transfer policies, Allied Health administrators do not have the tools to make articulation work.

- The federal government should support development of such articulation tools as challenge examinations for Allied Health education subject matter of a multidisciplinary nature.

Priority #8-- Increase the representation of ethnic minority group members in the Allied Health professions. Increasing the representation of minorities in the Allied Health professions is important to meet the health needs of diverse cultures and ethnic groups. Moreover, Allied Health professions represent an excellent avenue for social mobility for disadvantaged minorities, because they are among the limited number of professions and occupations in the economy for which the employment outlook is almost uniformly favorable.

- The federal government should support student aid programs and special projects for the disadvantaged (especially racial minorities) and the handicapped.

Priority #9-- Build the capability for leadership and innovation. Because of the dynamic nature of health-care delivery and rapidly changing practice needs, Allied Health education must not remain static. It is essential to develop the capability for leadership and innovation. More support is needed for the activities on which future improvements in Allied Health education and services are dependant.

- The federal government should support advanced programs on pilot or demonstration bases for the preparation of master clinicians and research on the effect of clinicians on the cost and effectiveness of health services.

- Support also should be made available for the establishment on demonstration bases of field stations, the purpose of which will be to increase the volume, quality, relevance, and utilization of research in Allied Health clinical services.

- Support also should be directed toward continuing education programs which teach planning and management skills to Allied Health professionals already in practice, including circuit-riding courses for practitioners in rural areas.

- Support is additionally needed for the development of institutes and workshops for administrators and faculty on a wide range of topics, including ways of relating education to practice needs and methods of attracting and retaining ethnic minority-group students.

- Finally, the federal government should support the establishment of 5 or 6 regional centers for research and development in Allied Health.

Priority #10-- Improve the information base for planning. Planning for Allied Health education at all levels currently occurs in an information vacuum, which results in wasteful duplication of effort. Manpower data are incomplete and outdated. Biennial inventories of collegiate Allied Health programs and programs in hospital settings are useful, but very little is known about Allied Health education which takes place in other settings.

- The federal government should support the systematic and continuous collection and dissemination of data on the numbers and distribution of health manpower in all professional areas, including information on projected openings.

- Support should be made available for the continuation of biennial national inventories of Allied Health programs, expanded to include all settings which offer formal post-secondary education programs.

- Support also is required for the development of a system of cost accounting for Allied Health programs, designed to identify actual program costs, costs-per-student, and comparative program and institutional costs to be used by educational institutions, health and education planners, and professional associations at local, state, and national levels.

- The federal government should support research on:

  --The cost effectiveness of Allied Health educational processes,
  --The impact of various institutional environments and program characteristics on competency attainment,
  --Allied Health faculty characteristics and continuing development needs, and
  --Methods of making Allied Health education responsive to such special service needs as those of rural and urban underserved areas.

ASAHP Recommendations for Statutory Change

Following are the elements of change which the American Society of Allied Health asks this Subcommittee to include in its version of extended and amended health manpower-training authorities. The elements generally incorporate amalgamations of the recommendations developed for the Subcommittee and other policymakers by both the Bureau of Health Manpower and the National Commission on Allied Health Education.

1. The Definition of "Allied Health Personnel" [Section 795 (1)] : Current statutory language defines "Allied Health personnel" as "individuals with training and responsibilities for (A) supporting, complementing, or

supplementing the professional functions of physicians, dentists, and other health professionals in the delivery of health care to patients, or (B) assisting environmental engineers and other personnel in environmental health control and preventive medicine activities." The extant statutory portrait of Allied Health professionals is completed in the section 795 (2) definition of "training center for Allied Health professions," which lists as the only examples of those professions "medical technology, optometric technology, and dental hygiene."

The portrait is inappropriate and, as we shall offer later, largely unnecessary. It is inappropriate for three reasons:

> a. The definition uses the term "personnel" rather than the term "professional." Physicians and dentists and unidentified others are "professionals;" Allied Health practitioners are "personnel." The distinction is inappropriate and, we think, derogatory. We note with pleasure Senator Kennedy's attempt to end the distinction by referring to all health-care practitioners affected by title VII as "personnel." His use of the term "professionals," applied without prejudice, would have been at least as acceptable.
>
> b. The definition suggests that Allied Health professionals always and everywhere work for or under the supervission of physicians, dentists and environmental engineers. That's simply not true.
>
> c. Finally, the definition puts forward as explicit examples of Allied Health practitioners not the physical or occupational therapist, the audiologist or speech pathologist, the dietition or clinical psychologist, but rather the individuals who function (medical technologists excepted) as aides and assistants. The examples are not inaccurate--these professionals are Allied Health practitioners; they are, however, not nearly as representative of the Allied Health fields as other choices would be.

Let me cite just one example of the unfortunate effects of the present definition's inappropriateness: The American Speech-Language-Hearing Association has long suggested to its members that they should not seek federal training assistance under the Part G Allied Health authorities of Title VII. To do so, the Association has said, would be to admit that speech pathologists and audiologists are something less than "professional." Training program directors who are members of that distinguished Association agreed--principle was of preeminent importance. It should come as no surprise, then, that speech pathology and audiology are two of the three Allied Health professions in which, according to the Bureau of Health Manpower, there are critical manpower shortages nationwide.

Senator Schweiker's proposal (S. 2144), in its section 700 (a), attempts to rectify the definition's inappropriateness by deleting, in the subsection (8) definition of "training center for Allied Health" and "school of Allied Health," all references to examples of the Allied Health professions. We strongly endorse the Senator's subsection (8) definition.

In his bill's subsection(7), Senator Schweiker has attempted to complete the portrait of "Allied Health personnel" by detailing who they are not (i.e., "graduates of schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, and public health and graduate programs in health administration"). We applaud the Senator's effort. What we would prefer, however, is the omission of any definition of "Allied Health personnel" [as in section 795 (1) of the Act and 700 (a)(7) of S. 2144]. Medical personnel are not defined, nor dental personnel, nor podiatric personnel; rather the schools which train such personnel are defined. We believe that the same standard should apply to the Allied Health field and, therefore, urge the Subcommittee to--

> delete section 795 (1) of the current statute and amend the current section 795 (2) by substituting, in lieu thereof, subsections (A), (B), and (C) of section 700 (a) (8) of proposed S. 2144. Subsection (D) of existing section 795 (2) should be retained.

2. Advisory Council Inclusion of Allied Health Representation: Both the Kennedy and Schweiker proposals would amend existing section 702 (a) language so as to accommodate representation on the National Advisory Council on Health Professions Education by a representative of Allied Health schools, and potential representation by a student enrolled in an Allied Health curriculum. We endorse these proposals. The Council has gone too long without a

representative of the educational institutions which train the largest segment of the health-care workforce. We, therefore, recommend that the Subcommittee adopt the proposals of Senators Kennedy and Schweiker which would--

> add representatives of Allied health schools (and of the student bodies of such institutions) to those health profession school representatives presently listed in section 702 (a) of Title VII as members of the National Advisory Council on Health Professions Education.

3. Data Collection in Allied Health: According to the recent reports of the Bureau of Health Manpower and the National Commission on Allied Health Education, support for data collection in Allied Health should be at the top of the federal government's Allied Health support agenda. Says the Report of the Bureau of Health Manpower:

> "There are insufficient data about allied health personnel at the local, State, or national level to permit radical improvements in planning, production, and management. The large number of occupations and functions involved, and their interrelations, makes good planning for allied health personnel difficult. Improved data on production, recruitment, reimbursement, utilization, service costs, and work force quality are needed. Data on improvements in supply, work force quality, educational standards and methods, and opportunities for minorities are difficult and costly to produce and generally less than satisfactory. Where improvements have occurred, Federal support appears to be a decisive factor."

According to the National Commission:

> "The federal government should support the systematic and continuous collection and dissemination of data on the numbers and distribution of health manpower in all occupational areas, including information on projected openings. Support also should be made available for the continuation of biennial national inventories of Allied Health programs, expanded to include all settings which offer formal post-secondary education programs.

The Commission's emphasis on data collection from "all occupational areas [and] settings which offer formal postsecondary education programs" merits special note. At present, the federal government supports Allied Health related data collection which relates only to Allied Health schools defined in existing section 795(2) -- i.e., schools which award the associate or baccalaureate or higher degree. There is, however, a large number of certificate-awarding Allied Health institutions (and an increasing number of Allied Health aide, assistant, and orderly-type graduates of such schools) regarding which data is not being collected. Clearly, this data needs to be gathered and analyzed. It should be and, we would urge, can be gathered without altering in any way the statutory definition of the Allied Health schools which are appropriate recipients of the federal training support.

There also is a pressing need for feasibility studies on the collection of data relating to ethnic minority-group member involvement in Allied Health training and practice. Data on approaches to career counseling, recruitment, admissions, and retention of minority-group students in training programs are required, so that we can understand (and deal with) the reality of greater student involvement at lower levels of training. We also need definitive studies on the impact of minority institutions on the overall Allied Health manpower pool and on the reasons for unique minority-group member practice patterns and geographic distribution.

In view of the foregoing, the Society asks the Subcommittee to --

> either amend the existing data-collection language of 708 or add a new section to Part G to accommodate the need for the collection of Allied Health related data from schools of Allied Health (including post-secondary nonprofit and proprietary institutions which grant practice "certificates" in Allied Health disciplines), including data relating to production, recruitment, reimbursement, utilization, service costs, workforce quality, educational standards and methods, and opportunities for minorities.

4. Allied Health Project Support: Existing section 796 authorizes $26 million in grants and contracts to "eligible entities" for special projects which are detailed in subsection (a)(1) of the section, With one notable

exception (*i.e.*, projects to establish "new roles and functions of allied health personnel"),--

> the purposes of section 798 should be retained in the Subcommittee's final legislative proposal. In addition, the following project-support emphases should be added to those already enumerated: projects which focus on Allied Health role delineations and related interdisciplinary curriculum modules; on meeting new health-service needs without creating new specialities; on the development of mechanisms for interdisciplinary articulation; on the use of Allied Health practitioners in containing health-care costs; on the Allied Health related needs of unserved and underserved areas; and on curriculum offerings in health promotion, disease prevention, geriatrics, and health planning. The authorization levels for existing section 796 should be $30 million for fiscal 1981, $32 million for fiscal 1982, $34 million for fiscal 1983, and $36 million for fiscal 1984.

5. Training Institutes in Allied Health: Existing section 797 authorizes $5.5 million for the current fiscal year for institutes generally designed to accomodate the "advanced" learning needs of Allied Health practitioners who, principally as a result of the rapid expansion of the Allied Health fields and increases in the numbers and varieties of Allied Health opportunities and initiatives, find themselves in new educational, supervisory or administrative settings. The Society believes that this emphasis should be continued and, therefore, recommends that the final Subcommittee proposal should--

> include existing section 797 through fiscal year 1984 at annual authorization levels which are equal to that of the current fiscal year.

6. Ethnic Minority-Group Allied Health Education: As the National Commission on Allied Health Education points out, the Allied Health professions, because they are among the few professions in the economy for which the employment outlook is almost uniformly favorable, "represent an excellent avenue for social mobility" on the part of ethnic minority-group members.

Moreover, notes the Commission, "minorities are substantially underrepresented in educational programs for the relatively high-level Allied Health occupations (i.e., baccalaureate and advanced degree levels)." Minority Allied Health training programs also are underrepresented -- among programs receiving Allied Health training assistance from the federal government. In the last year for which data are available (1975), the 563 Allied Health discipline programs situated in minority institutions represented 10 percent of the total Allied Health program offerings. Yet minority institutions received only six percent of Allied Health training assistance made available through the Bureau of Health Manpower. The Society asks that the Subcommittee include in its final legislative proposal authorizations designed to--

> provide student support for disadvantaged ethnic minority-group members enrolled in Allied Health education programs (especially in baccalaureate and graduate programs), and special program support for Allied Health education programs in traditionally and predominantly minority institutions. In addition, the special recruitment and related emphases of existing section 798 should be continued at the current authorization level.

Senator Kennedy's proposed section 787 represents an exemplary attempt to accommodate this Society recommendation.

7. National Health Service Corps: A significant aspect of the Congress' rationale for initiating, in 1966, federal-support programs in Allied Health education was its belief that the Allied Health professions could help the health-care delivery systems need to increase services to unserved and underserved areas of the country. Allied Health has since proven its effectiveness in these areas -- Allied Health services are diverse; so are the critical health-care needs in unserved rural and urban areas. Yet the Allied Health professions have been virtually ignored by National Health Services Corps planners.

In 1979, for example, only 28 of 2,379 NHSC scholarships went to Allied

Health students (all 28 were awarded to master's level students in public health nutrition programs). We find it hard to believe that podiatry services, for example, are any more crucial to the health-care needs of underserved populations that the services of audiologists or physical therapists or rehabilitation counselors (106 podiatry students benefitted from NHSC assistance in 1979). The Society asks that the Subcommittee--

include students in the Allied Health professions among the health professions students qualified for NHSC education assistance and service.

8. National Priority Initiatives: The Society applauds proposals designed by Senators Kennedy and Schweiker to focus special federal support on specified health-care priority needs. We would agree that--

clinical training, health policy and health-care economics, continuing education, educational costs, curriculum development, and the role of women in health-care education and service are all appropriate areas for special federal funding emphasis. Allied Health training programs should be specified as appropriate recipients of such special funding.

Regarding Senator Kennedy's call for emphasis on the role of women in training and service delivery, we want to suggest that, inasmuch as women comprise approximately 75 percent of the present Allied Health workforce, but occupy only a very small percentage of Allied Health leadership positions, relevant legislative emphases should be on the movement of Allied Health professionals who are women into leadership roles. We also would appreciate a Subcommittee proposal designed to encourage the increased involvement of men in the Allied Health professions.

9. Significant National Allied Health Shortages: The Bureau of Health Manpower has listed the Allied Health professions in which there are (or appear to be) "significant national shortages." We ask the Subcommittee to include in its final measure an amendment to existing section 796 which would--

enable the Bureau of Health Manpower to provide special incentive support to Allied Health education programs which train students in disciplines identified as "significant national shortage" areas, notably audiology, speech pathology, respiratory therapy, dietetics, dietetic technology, physical therapy, occupational therapy, radiation therapy, and dental assisting.

* * * * * * *

The American Society of Allied Health Professions greatly appreciates this opportunity to present its views.

Mr. **Waxman**. Thank you very much.

You suggest there are more than 14,000 allied health programs in the country now. During the time of budget cuts how can the amounts of money that we can realistically request for allied health be best distributed?

Should we target the money to the specific shortage specialties that the two reports identified?

Mr. **Dowling**. The Kellogg Commission report addresses those problems in a realistic way. Its primary recommendation is for the kinds of project support already authorized under current law and which would continue to be authorized under your bill for what the commission calls role delineation studies.

We are not training students. We are providing project support for universities and other entities so they can better develop the allied health education system. None of the money goes for student assistance; none of the money appropriated for the better part of the last decade has gone for student assistance.

A role delineation study which the commission calls for would investigate ways in which existing professions can better serve the populations who need health care services; can we train maybe people who are better equipped to do two or three or four jobs? There has been a great proliferation among health care disciplines. Every time a new technology is invented a new profession grows up.

It may be an EKG technician can do more than that job; perhaps he can learn the skills of an EEG technician as well. It may be that curriculum can be developed for the training of both occupational and physical therapy so they can begin to combine their expertise and combine their ranks as well.

With respect to the targeting of money on manpower shortage areas, yes, we believe that some of the funds authorized by section 796 should be put to this purpose.

Mr. **Waxman**. What sort of financial aid can a student of allied health professions obtain?

Mr. **Dowling**. Some money from the Defense Department and some money from the Office of Education and some money through the States—the same kind of educational assistance which somebody enrolled in an undergraduate liberal arts program can obtain—and not very much else.

There has been in past years, though not very much for the last 5 or 6 years some money available from the Rehabilitation Services Administration for some professions, a very few of which are allied health professions.

To a very limited extent physical therapists and to a greater extent speech pathologists have received some money from the Office of Education's Bureau of Education for the Handicapped, designed to send people into the public schools. That's about it and it's not much.

Mr. **Waxman**. We are certainly sympathetic to the problems you raise and we will see what we can do.

Mr. **Dowling**. Thank you very much.

Mr. **Waxman**. Our last two witnesses will testify as a panel on aggregate physician supply and the impact on the economy. First we have Dr. H. David Banta, Health Program Manager, Office of Technology Assessment, Congress of the United States and Dr. Jack Hadley, senior research associate, Health Policy Program, The Urban Institute.

We would like you to summarize your statement if you would and your full comments will be made part of the record.

STATEMENTS OF H. DAVID BANTA, M.D., HEALTH PROGRAM MANAGER, OFFICE OF TECHNOLOGY ASSESSMENT, CONGRESS OF THE UNITED STATES, ACCOMPANIED BY LAWRENCE MIIKE, PROJECT DIRECTOR (OTA STUDY); AND PAMELA DOTY, CONGRESSIONAL FELLOW (OTA STUDY); AND JACK HADLEY, PH. D., SENIOR RESEARCH ASSOCIATE, THE URBAN INSTITUTE

Dr. **Banta**. I am pleased to appear before you to discuss the study the Office of Technology Assessment has carried out on "Forcasts of Physician Supply and Requirements."

With me are Lawrence Miike and Pamela Doty who worked on the study.

The study was requested by this committee and by the Senate Committee on Labor and Human Resources because of concern about estimates of the number of physicians required to meet national needs and the projection of future supply.

The report will be published shortly by the Government Printing Office. The committee has been furnished copies.

As with all OTA studies an advisory panel was convened chaired by Dr. Harvey Estes who testified on Monday. Dr. Hadley was a member of the panel.

We focused on two models. The model developed by the Bureau of Health Manpower is an economic one based on an assumption that supply and demand were in balance in 1975. This model gives only aggregate data so it does not tell us, for example, whether we need more primary care physicians.

The Graduate Medical Education National Advisory Committee model is based on medical needs and will estimate specialty by specialty requirements. GMENAC has no results yet, so we concentrated on the Bureau's model.

Under that model the supply of active physicians is projected to be approximately 450,000 in 1980; 525,000 in 1985 and 600,000 in 1990. We find these estimates are generally reasonable.

Projections of future requirements are separated into two parts; one, effects due to population growth and changes in age, sex, and income distribution of the population. Two, effects due to what the Bureau describes as a long-term trend to increased per capita use of medical services.

The first set of changes are reasonable and lead to a 1990 demand of 415,000 physicians. The second set of changes are not reasonable in our opinion.

We have concluded that the increase in demand is overestimated and there is a discrepancy of up to 185,000 physicians in the 1990 projections of supply and demand. In short it appears that not only will the shortage of physicians be solved but such a large number of additional physicians may have trouble finding places in the health care delivery system.

I should emphasize that the model does not take into account physician productivity. If it is considered desirable for physicians to spend a few extra minutes with each patient or to have shorter work weeks, much of the projected supply of 600,000 physicians could be appropriate.

For example, the average weekly load of family practitioners is presently about 171 which means they see 6.2 patients per hour. Experts have said that a primary care physician ideally should see about four patients per hour. One can calculate roughly that such a change could require an increase of as many as 75,000 physicians.

I was asked to make some comments on the financial costs of these physicians. Costs per physician has two components. First there are the direct costs of the physician's services and second there are the indirect costs to the health system that a physician generates by admitting patients to the hospital and the nursing home, by ordering tests and drugs and so forth.

We do not feel it is possible to project the indirect costs in 1990 although there will be such costs. We can say physicians will try to maintain the same income they presently earn. Although this amount may fall, as Dr. Hadley will discuss, a calculation can illustrate in rough terms what these physicians may cost society.

The expenditure for physician services in 1978 was about $35 billion. We can estimate that increasing the number of physicians to 600,000 could increase that amount more than $18 billion to about $54 billion in 1978 dollars.

What these numbers mean is we are going to have a very large supply of physicians and unless things change they will be very costly. In part the extra physicians may meet needs presently not being addressed. However, this country does not have effective policy mechanisms to help assure that physicians will in fact set up practice in underserved areas or they will elect to enter primary care as a field.

We would suggest that we must begin now to think through the implications of this large supply of physicians and begin to plan how to use them.

Thank you very much, Mr. Chairman.

[Testimony resumes on p. 759.]

[Dr. Banta prepared statement with attachments follow:]

STATEMENT OF
H. DAVID BANTA, M.D., HEALTH PROGRAM MANAGER
OFFICE OF TECHNOLOGY ASSESSMENT
CONGRESS OF THE UNITED STATES

Mr. Chairman and Members of the Subcommittee:

I am pleased to appear before you to discuss the study the Office of Technology Assessment (OTA) has carried out on Forecasts of Physician Supply and Requirements. With me today are Lawrence Miike, project director for the OTA study, and Pamela Doty, a Congressional fellow in our Office who worked on the report.

The study was requested by this subcommittee and its parent Committee on Interstate and Foreign Commerce and by the Senate Committee on Labor and Human Resources. The study was initiated because of concern from both committees about estimates of the number of physicians required to meet national needs and the projections of future supply. It was anticipated that Congress would be dealing with the more difficult issues of specialty and geographic maldistribution, and would rely heavily on forecasting results in formulating policies toward physician training. OTA was asked to analyze the assumptions underlying the different forecasts, as well as the methods and conclusions of the forecasts themselves, in order to determine which forecasting technologies are most reasonable. Indeed, there have been wide variations in the forecasts of how many physicians are needed, of what types, and where they should be practicing.

The report will be published shortly by the Government Printing Office. The Committee has been furnished copies. We have also appended to this testimony the Summary and Conclusions chapter of the report. As with all OTA studies, an Advisory Panel was convened to assist us with the study. The Panel was chaired by Dr. Harvey Estes, Chairman of the Department of Community and Family Medicine of the Duke University School of Medicine. A full list of Panel members is attached.

The supply of active physicians is projected to be approximately

450,000 in 1980, 525,000 in 1985, and 600,000 in 1990. Compared to a 1975 supply of 370,000, the net increase will average 75,000 every 5 years.

As a percent of the total supply, physicians in general practice, family practice, internal medicine, and pediatrics, the specialties usually referred to as the "primary care" specialties, are projected to comprise 39% in 1980, 41% in 1985, and 42% in 1990. The largest specialty will be internal medicine, which will have more than twice as many physicians than any one of the other specialties.

The geographical, or locational, distribution of the projected supply, by specialty, is estimated by similar methods as for aggregate and specialty supply; i.e., current supply plus additions. At the Federal level, locational projections are used to identify those locations with the least number of physicians for programs which intend to place physicians (e.g., the National Health Service Corps) or for which shortage designation is necessary to quality for government funds, such as reimbursement of the services of nurse practitioners and physicians' assistants in rural areas.

Projections of specialty and locational supply depend on the standard method of relying on historical data to predict future events, and in particular, on most recent experiences to predict the most immediate future. But legislation has purposely tried to affect physicians' specialty and location choices, and, given the lag time between physician education and eventual practice, data from the late 1960's and early to mid 1970's still reflect past policies, not current ones. Thus, the usual finding of "inadequate data" is particularly applicable for physician specialty and locational projections.

Generally, the methods behind forecasts of the numbers of physicians "required" have to make explicit or implicit assumptions on: (1) the population's level of use of medical services, and (2) physician productivity, or how much service each physician provides.

The Bureau of Health Manpower's estimates of the economic demand for physicians' services are derived from known per capita use rates projected into the future. The model assumes that supply and demand were in balance in 1975. Projections of future use are separated into: (1) effects due to population growth and changes in the population's age, sex, and income distributions, and (2) effects due to what the Bureau has identified as a long-term trend toward increased per capita use of medical services. Physician productivity is assumed to remain constant.

Using 1975 use rates, demographic changes are projected to lead to a 10 percent increase by 1990 over 1975 demand, or 415,000 physicians in 1990 versus 378,000 in 1975. Using a trend factor of increasing use based on 1968-1976 data, an additional increase of 185,000 in physician demand is projected for 1990. Thus, the total projected demand for physicians in 1990 is 600,000, or what the projected supply will be.

We have concluded that the increase in demand attributable to a historical trend toward increased per captia use is overestimated. The period 1968-1976 is used to establish the trend, but whereas a start date of 1968 yields a distinctly upward trend for physicians' office visits, a start date of 1971 yields a downward trend.

How much of this 185,000 is an overestimate? This not only depends on changing patterns of use, but also on physician productivity. To some extent, these are policy choices to be made. If it is considered desirable for use to rise, for physicians to spend a few extra minutes with each patient, or for physicians to have shorter workweeks, much of the projected supply of 600,000 physicians in 1990 could be appropriate. For example, the average weekly patient load of family practitioners is presently about 171, which means that they see about 6.2 patients per hour. Experts have said that a primary care physician should ideally see about four patients per hour. One can calculate in rough terms that if all primary care practitioners were to spend 15 minutes with each patient, they would each have 3,000 fewer visits in a year. The pool of primary care practitioners would have to be increased by a factor of one-and-one-half. In 1977 there were 139,000 active primary care physicians. Making this one change would require about 216,000 physicians, an increase of more than 75,000. Thus, it is not difficult to see how 185,000 physicians can be absorbed into our health care system in an effective and socially useful manner.

The Bureau of Health Manpower's model, as presently constructed, can only provide aggregate, and not specialty-specific physician requirements, because demand is grouped by health care setting, not by specialty care.

A medical opinion estimate of specialty-by-specialty "requirements" could overestimate aggregate physician requirements because of the difficulty of reconciling overlapping patient care responsibilities. This task is presently being undertaken by the Graduate Medical Education National Advisory Committee to DHEW.

An unresolved issue, however, is the requirements for primary care specialties. There are basic differences on what is primary care, disagreement over what specialties constitute the primary care ones, and the pragmatic problem that other specialists will continue to provide similar services even if there were agreement on what primary care is. The models cannot be expected to resolve these issues. Resolution of these issues is a pre-condition to projecting the requirements for the primary care specialties.

Even if national aggregate and specialty requirements were satisfied, it would be unlikely that physicians would be evenly distributed in all geographic areas or equally accessible to all population groups. Estimates of locational requirements are used in operating programs designed to provide physicians and other medical care resources to targeted populations. These "requirements" are based not only on assumptions about what are appropriate types and quantities of medical services, but also on: (1) how medical services should be redistributed, and (2) the amount of care that the Federal government should provide or finance compared to other public and private sources. Thus, the number of Federally-designated Health Manpower Shortage areas reflects that quarter of the U.S. having the least number of primary care physicians, and the number of physicians the Federal government will provide through the National Health Service Corps is based on an "appropriate" extent of Federal involvement.

While projections of supply and requirements depend on historical data to predict future events, it is clear that legislation in this area has purposely tried to affect physicians' specialty and location choices. Disputable assumptions of what ought to happen have been made as though they were questions of methodology and not policy. Greater awareness of the limits of forecasting and less preoccupation with a particular set of numbers would be possible if the assumptions underlying the projections are made more explicit; alternative forecasts are projected, based on different sets of assumptions; and participation in the forecasting process is expanded to include policymakers as well as the technical community.

The request for this report was for clarification of the numbers that have been tossed about in the health manpower policy arena. Its purpose was to clarify the information that fuels the policy process. Given the specific nature of our charge and the limited time in which to accomplish it, we purposefully did not address the health manpower policy implications and options of our findings. For example, whether the National Health Service Corps should be the primary means of addressing physician locational maldistribution, the size of the Corps, whether its members should be recruited directly or by scholarships, the relationship of Corps funding and medical school funding, etc., are all issues that are related to forecasts of future "requirements." Another area is graduate medical training programs, and, as we have indicated, there is still no consensus of what primary care consists of, whether we can specifically itemize specialty-by-specialty needs, and if we can, whether such targets should be legislated ones or not.

However, a major policy implication of our greatly-expanding supply of physicians is the matter of costs, and so we have prepared a short Postscript on "Future Expenditures on Physician Services." It is not a part of the report, but is attached as part of this testimony.

Recall that, against a 1990 supply of 600,000 physicians, population changes from 1975 would account for requirements of 415,000. We questioned the Bureau of Health Manpower's conclusion that rising per capita use would account for all of the other 185,000 as being "required," but also pointed out that requirements were highly sensitive to different assumptions about future per capita use and productivity.

We have been asked to make an estimate concerning the probable cost implications of the estimated supply of 600,000 physicians in 1990.

The cost in terms of annual medical care expenditures per physician has two components. First, there are the direct costs of the physician's services. This figure would include the physician's personal income before taxes plus professional expenses such as maintenance of an office and an office staff. Second, there are the indirect costs of revenues to the health system that a physician generates by admitting patients to hospitals and nursing homes, by ordering tests, prescribing drugs, and so forth.

For reasons we will only briefly go into here, we believe that it is virtually impossible to come up with a responsible estimate encompassing indirect costs per physician in 1990, but that it is possible to at least stake out the parameters of gross billings for physicians' services in 1990.

The difficulty in estimating indirect costs likely to be generated by the 1990 supply of physicians is that it is too simple to project current average cost impact per physician onto the 1990 physician supply. As any economist will tell you, what would be needed is an estimate of the marginal cost impact of each new physician added to the expanding physician supply. To assume marginal cost impact equal to current average cost impact as the physician supply continued to expand would be to assume that there are no constraints at all on the amount of services physicians can provide. Yet we know that there are constraints. To give but one example: Efforts are now underway to cut back or at least curtail growth in the supply of hospital beds. If, as we anticipate, the supply of physicians between now and 1990 continues to increase much more rapidly than both the population and the supply of hospital beds, then, clearly, at some point, the increased supply of physicians will result in lowering the average physician's number of hospital admissions.

In brief, to estimate marginal cost impact per addition to the physician supply, and from there to project total physician-generated medical expenditures in 1990, it would be necessary to develop a complicated mathematical model, whose accuracy would depend on variables it is not now possible to predict with any degree of certainty.

Accordingly, we have chosen a simpler, more straightforward approach that focuses on physicians' incomes. We start from the common sense proposition that physicians in 1990 would want and expect to earn at least as much on average as physicians currently practicing earn. Employing net and gross income figures from Medical Economics Magazine's Continuing Survey of office-based physicians, we have estimated the amount of gross billings for physicians' services that would need to be generated to sustain all 600,000 physicians at approximately the current average physician's income. Assuming an annual inflation rate of 4.2%, this figure would amount to $87.7 billion; if the inflation rate were 7.7%, then annual gross billings would need to be at least $130.4 billion. These figures are conservative estimates. Details on how we made these calculations and why are spelled out in the accompanying materials we have provided. One obvious point is that the current inflation rate is much higher than the rates we have used. Thus, if present economic conditions were to continue, the figures given here would represent a decline in physician's real incomes. For comparative purposes, the Health Care Financing Administration's estimate of total expenditures for physicians' services in 1978 was $35.3 billion.

We also need to ask whether physicians in 1990 might realistically be able to generate this level of gross billings. Each individual physician needs to generate more income annually to keep pace with inflation, and he or she has only two means available: (1) seeing more patients, or (2) providing more services per patient or charging higher fees per services. We have seen, however, from our analysis of the Bureau of Health Manpower's requirements estimates that, given the expected 10% population growth, if the 1990 population does not increase its per capita use of physicians' services above present levels, then only 415,000 physicians would be required. This estimate assumes that physicians would continue to treat the same numbers of patients as currently; that is, they would maintain productivity. Whereas there were major increases in per capita use of services in the late 1960's (due, we believe, to expansion of private health insurance as well as Medicare and Medicaid), the per capita use of physicians' services has leveled off in the 1970's. Unless there is enactment of a generous national health insurance package, or some other deliberate policy is undertaken that would stimulate consumer demand for medical care, we do not foresee significant increases in consumer demand for physicians' services.

If consumer demand for medical services does remain fairly stable, and growth in the physician supply rapidly outpaces population growth, then each new physician added to the supply will increasingly draw patients away from other physicians, instead of responding to previously unmet consumer demand. We would then expect physician productivity in terms of hours worked and patient visits to decline. Indeed, data from Medical Economics Magazine's Continuing Survey indicates that physician productivity for most specialties has been declining through most of the past decade.

Thus, to maintain real income at present levels, physicians would need to raise fees per unit of service and/or provide more services per patient. Though we expect increases, we don't believe the market would bear the kind of increases needed to sustain the expanded physician supply at current income levels in the absence of increased per capita use of physicians' services.

It is frequently argued, however, that physicians are at least partially exempt from the laws of supply and demand and that, faced with the conditions we have just outlined, they would induce increased demand for their services by prescribing more services per patient. However, a study by the Urban Institute of physician behavior during the 1973-1974 price freeze found that, although physicians did respond to declines in their real incomes by providing more intensive services to Medicare patients, the extent of the induced demand remained limited. In particular, the study noted that physicians did not induce sufficient increased demand for their services to compensate for the decline in real income brought about by the price freeze. The authors concluded that induced demand exists, but that physicians either cannot or will not employ it as an open-ended method for achieving a target income.

In sum, our analysis of the cost implications of the expanding physician supply suggests that, as of 1990, Americans will be paying considerably more both in total expenditures as well as per unit of service to maintain or slightly increase the current level of per capita use of physicians' services. These higher costs would probably be necessary to allow all 600,000 at the anticipated 1990 physician supply to remain in active medical practice at sufficiently attractive income levels. In return for higher costs, however, the patient would probably receive more of the doctor's time, since each physician would have a smaller patient load than is presently the case. Moreover, if the Urban Institute's findings about the limits on physicians' willingness or ability to induce demand are correct, then the implications for total medical expenditures in 1990 of the increased physician supply will not be as devasting as some have predicted. The implication for physicians, especially new physicians, is, however, that they should not expect their practice patterns to be the same nor their real incomes to be as high as 1990 as they are today.

Dr. Miike, Dr. Doty, and I are now prepared to discuss the findings of our report on Forecasts of Physician Supply and Requirements and any related matters you wish to explore.

CHAPTER I

SUMMARY AND CONCLUSIONS

INTRODUCTION

Reauthorization of the Health Professions Educational Assistance Act (P.L. 94-484) is scheduled for 1980. Essentially, the Act reflects Congress' policies toward medical and other health professions educational support and toward identifying and addressing the problems of medically underserved areas and populations.

The request for this assessment originated with the Senate Committee on Labor and Human Resources, supported by the House Committee on Interstate and Foreign Commerce. The Senate Committee's letter pointed out that there have been wide variations in the numbers and types of physicians "required," and that as the Congress begins to deal with the more difficult issues of specialty and geographic maldistribution, legislative policy will have to rely on such forecasting results and related forecasting technologies for estimating the adequacy of specialty and geographic distribution. It would therefore be helpful to the Congress that an analysis be undertaken of the assumptions underlying the different forecasts, as well as the methods and conclusions of the forecasts themselves, in order to determine which forecasting technologies are most reasonable.

Projections of physician supply and requirements have influenced Federal policy toward and legislation on health professions education and the problem of medically underserved areas, and play an important role in existing Federal programs whose purposes are to build up area medical resources or to provide medical services directly.

Until the 1976 Act, Federal policy was to increase the supply of physicians and other health professionals, because the perception was that of acute shortages. Although the expiring legislation contains incentives to continue to accelerate the supply of physicians, the general consensus now is that the aggregate supply of physicians is at least adequate and perhaps even in excess. Hence, attention has turned toward the problems of specialty and geographical, or locational, maldistribution.

Efforts at correcting specialty maldistribution have concentrated on the primary care specialties, which are usually identifed as general practitioners, family practitioners, general internists, and general pediatricians. All osteopathic physicians are also included, although this profession is becoming more specialized (about 40 percent are now specialists). Psychiatrists, obstetrician-gynecologists, and general surgeons have sometimes been included.

Definitional problems are obvious, and they are important in determining the requirements for primary care physicians. For example, primary care physicians may include only those categories identified as primary care; i.e., different combinations of the categories identified above. The underlying rationale is that the way in which medical care is provided is crucial. This approach sees primary care as requiring a change in attitude toward patient care, a holistic approach to patients and their families, and as providing the appropriate entry point into the medical care system. Others may concentrate on office-based ambulatory care regardless of the specialty designation of the physician providing such services and estimate requirements on that basis.

In addition to definitional problems, approaches toward primary care have been reminiscient of past approaches to aggregate physician supply; the emphasis has been on simply increasing the supply rather than simultaneously being concerned over what is an appropriate supply. Usually, this has meant that primary care objectives have been phrased in terms of the percent of the aggregate physician supply that should be in primary care. Such objectives would be inappropriate if aggregate supply were excessive.

Geographical or locational maldistribution is generally a problem where health personnel and services are found inadequate, by some defined standard, to meet the health needs of the population of the identified communities, areas, or institutional settings. Locational maldistribution is by definition a relative concept, where some of our people is determined to be at a disadvantage relative to the rest of the United States. Once these are identified, then the gap between health personnel and services and that population's needs for them is quantified to determine: (1) how many personnel is needed to bridge the gap, and (2) of the identified deficiency, how much of it will be addressed through a specific program.

Quantifying locational maldistribution serves two purposes. First, it is used as part of the eligibility criteria for Health Manpower Shortage Area (HMSA) designation for: (1) National Health Service Corps (NHSC) sites; (2) designation as service areas in which students who borrow money under health professions student loan programs can practice in lieu of repaying the loans in money; (3) grants for various health manpower training programs; (4) eligibility or preference for grant funds for several Bureau of Community Health Services programs, such as the urban and rural health initiatives; and (5) certification of rural health clinics for nurse practitioner's and physician's assistant's services reimbursement through Medicare and Medicaid.

Second, these methods to quantify locational maldistribution are used to plan for the future size of the National Health Service Corps. That is, given the estimated universe of existing and future HMSAs, plans must be made for determining how many of those medical manpower shortage areas will be staffed by

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NHSC physicians. Currently, the major source for those future NHSC positions are students who will be obligated to the NHSC in exchange for scholarship support.

CURRENT ACTIVITIES

Under the Health Professions Educational Assistance Act of 1976, the Department of Health and Human Services (DHHS) is required to provide annual reports to the President and the Congress on the status of health personnel in the United States. Estimating the present and future supply of and requirements for physicians and other health professions is the responsibility of the Health Resources Administration through its Manpower Analysis Branch of the Bureau of Health Manpower. DHHS has produced its first report (dated August 1978 and reprinted in March 1979) and is in the final stages of review for its next report.

In addition, DHHS chartered a Graduate Medical Education National Advisory Committee (GMENAC) on April 20, 1976, to make recommendations in three years to the Secretary on the present and future supply of and requirements for physicians, their specialty and geographic distribution, and methods for financing graduate medical education. Its most immediate impact will come from its recommendations on how graduate medical education (residency programs) should (could) be changed to meet these stated goals. GMENAC was given a one-year requested extension of its charter to April 20, 1980, at which time its final report must be submitted. An interim report was published in April 1979.

Finally, the Bureau of Labor Statistics of the U.S. Department of Labor includes physicians and other health occupations in its projections of occupational requirements and training needs. These projections relate manpower to projected economic demand (expenditures) as provided by the Bureau's model of the future economy, which projects the future gross national product (GNP) and its components -- consumer expenditures, business investment, governmental expenditures, and net exports; industrial output and productivity; the labor force; average weekly hours of work; and employment for detailed industry groups and occupations.

The Bureau of Labor Statistics considers the Bureau of Health Manpower's modeling efforts to be a more sophisticated effort than its own, and in its forthcoming revision of its estimates, will adopt the midpoint of the range of projections from the BHM model for its physician demand projections. Thus, there are essentially two major efforts currently underway, which will have immediate impacts on Federal health manpower policy; the sustained modeling activities of the Bureau of Health Manpower and the nearly completed deliberations of DHHS's Graduate Medical Education National Advisory Committee. These two activities also illustrate well the different approaches through which physician supply and requirements projections can be made.

FINDINGS AND CONCLUSIONS

SUPPLY

Forecasts of the future supply of physicians consist of: (a) current supply, adjusted for attrition from deaths and retirements, and (b) additions to supply from (i) graduates of U.S. medical and osteopathic schools and (ii) immigration of physicians educated in other countries plus U.S. citizens educated in foreign medical schools. The supply of active physicians is projected to be approximately 450,000 in 1980, 525,000 in 1985, and 600,000 in 1990. Compared to a 1975 supply of 378,000, the net increase will average 75,000 every 5 years.

Bureau of Health Manpower estimates of additions to supply from graduates of U.S. medical and osteopathic schools take first-year enrollment projections, adjusted for attrition, to arrive at the number of graduates per year. Estimates of first-year enrollments are based on trends in: (1) Federal capitation support, (2) Federal construction grants activity, (3) new schools already planned, and (4) potential State and local support of new schools.

Estimates of additions to supply from immigration of physicians educated in other countries are currently based on the presumed impact of the Health Professions Educational Assistance Act of 1976, which was designed to sharply curtail the immigration of physicians into the U.S.

GMENAC's approach to estimating supply (not yet completed) uses a different way of disaggregating the U.S. medical school graduate source. They will project graduates for each school, based on information provided by the Association of American Medical Colleges.

Although predictions of the future supply have been consistent in the aggregate over the past five years, the additions -- domestic and foreign graduates -- have changed considerably. Current projections may overestimate the number of future domestic graduates because of the assumption of full capitation funding. In contrast, the addition to supply from foreign medical graduates, projected to be 1,000 to 2,000 in the 1980's, could be unrealistically low. U.S. students studying abroad (currently under study by the General Accounting Office) may not be adequately accounted for and could double the 1,000 to 2,000 additions per year from foreign medical schools in the 1980's.

The net effect of overestimating domestic sources and underestimating foreign sources could "wash" each other out.

Supply projections leave the impression that 600,000 physicians in 1990 is a fixed number. But the assumptions currently in use explicitly recognize the influence of policy on supply. Estimates based on different sets of assumptions could provide better indications of the variability of the projected supply and of the influence of deliberate policy decisions on the ultimate numbers.

For foreign graduates, the presumed full impact of P.L. 94-484 is deliberately factored into the model. For domestic sources, full capitation and continued development of new medical schools in the 1980's are also assumed. The latter also reflects a presumed full impact of existing Federal law, but past experience and current consensus would deny the real possibility of ever gaining authorized capitation levels, although private medical schools continue to be developed. And the impact of P.L. 94-484 on dampening foreign medical graduate sources may be circumvented by the increasing number of U.S. citizens studying medicine abroad and eventually returning to the U.S. to practice.

The specialty distribution of the projected supply is estimated by taking the number of active practitioners by (self-designated) specialty, adjusted for death and retirement, and distributing graduates among the specialties through projections of first-year residency trends.

Trends in first-year residency positions are used to predict future specialty distribution because of lack of data on final-year residency positions. However, first-year residency positions are often used for general clinical experience prior to concentration in a particular subspecialty or in another specialty and therefore do not necessarily represent final specialty choices; i.e., first-year residency counts are duplicative for particular specialties in that a proportion move on to sub-specialization or to another specialty altogether. BHM's current projections assume that the first-year residency distribution trends for 1968, 1970-74, and 1976, also apply through 1980-81. After 1980-81, the residency distribution is held constant for the statistical reason that the base years chosen to establish the trend cover 6 years, so BHM has chosen not to extend the extrapolation beyond 6 years. Downward adjustments are made to minimize double-counting; the greatest adjustments occur in general surgery (62 percent) and internal medicine (32 percent).

As a percent of the total projected supply, physicians in general practice, family practice, internal medicine, and pediatrics (those usually counted as primary care specialties) are projected to comprise 39% in 1980, 41% in 1985, and 42% in 1990. The largest specialty among these, as well as among all the specialties, will be internal medicine, which will have more than twice as many physicians than any one of the other specialties.

The locational distribution of the projected supply, by specialty, is estimated by similar methods as for aggregate and specialty supply; i.e., current supply plus additions. These locational projections can be disaggregated in a variety of ways; e.g., by geographic criteria such as by states, counties, Census-defined State Economic Areas, or Health Service Areas, or by special populations such as institutional care (mental hospitals, prisons), the indigent, and Native Americans.

Locational projections are used to identify those locations with the least number of physicians for programs which intend to place physicians (e.g., the National Health Service Corps) or for which shortage designation is necessary to qualify for government funds.

The process of designating and staffing Health Manpower Shortage Areas (HMSAs) presently includes estimating the future supply of physicians for: (a) rural counties, (b) urban areas, (c) Federal, State, and local prisons, (d) State mental hospitals and community mental health centers, and (e) the Indian

Health Service.

Projections of specialty and locational supply depend on the standard method of relying on historical data to predict future events, and in particular, on most recent experience to predict the most immediate future. This can be seen in the use of mid-to-late 60's to mid 70's data to predict 1980-1990 patterns. Aside from the inevitable finding of "inadequate data" which, for one of the most important marker specialties (internal medicine), contains an error factor of at least 32 and perhaps as high as 62 percent in the first-year residency count, the use of historical data has two other limitations in these projections of specialty and locational distribution. The late 60's and 70's have witnessed: (a) Medicare and Medicaid and greater third-party private insurance coverage, (b) unprecedented increases in medical school enrollments and a large influx of foreign medical graduates, and (c) major changes in graduate medical education, including abolition of the free-standing internship and its selective replacement by the first-year of some residency programs. Second, legislation in this area has purposely tried to affect physician specialty and location choices, and, given the lag time between physician education and eventual practice, late 60's and early to mid 70's data reflect past policies, not current ones.

REQUIREMENTS

Estimates of the numbers of physicians required in the future are derived by dividing the amount of services that it is anticipated physicians will or should provide a given population in a given year, by physician productivity. Estimates of a population's economic demand for services measure the capacity of the population to use physician services and are not limited to physician care that is essential to the patient's health. In general, physician productivity is assumed to remain constant. Thus, the difference between forecasting models is essentially one of differences in the estimates of use.

Although productivity is generally assumed constant, the particular measure chosen will directly influence the estimates of physician requirements. For example, GMENAC's workbook for estimating general surgeon requirements lists alternative estimates of average weekly office visits that could be used as productivity measures as 77.2, 58, 51, and 43.

The Bureau of Health Manpower's estimates of economic demand for physician services in 1990 are derived first from current per capita use rates projected onto the 1990 population. These figures are then adjusted for what the Bureau identifies as a long term trend toward rising use of services, based on analysis of historical changes in per capita utilization during the period 1968-1976. Thus, projections of future use can be separated into: (a) effects due simply to population growth and changes in the population's age, sex, and income distribution and (b) effects due to a projected long-term trend toward increased per capita use apart from demographic considerations.

The Bureau of Health Manpower's model projects the U.S. population by age, sex, and income subgroups, and use rates for each of these (40) subgroups are estimated for 20 types of health services settings. The historical trend in per capita use is separated into price and non-price related components. The price related component interprets the effects of trends in out-of-pocket costs to consumers on changes in use. Projections of increased demand for physician services in 1990 calculated on the basis of a presumed trend toward rising per capita use of services are, however, highly sensitive to the particular start date chosen for the trend analysis. Stated another way, the assumption that there is a currently ongoing strong historical trend toward rising per capita use that can be projected to continue to 1990 is highly dependent on using the particular historical period 1968-1976 as the basis for calculating the trend factor. If a more recent period were used to calculate the trend, the projected growth rate in per capita use would be considerably more moderate.

The Bureau of Health Manpower's model assumes that supply and demand were in balance in 1975. This is a mathematical convenience to provide a constant base against which the relative magnitude of projected future changes can be referenced. However, prior estimates on aggregate demand have generally reached this conclusion (Table 25). Using current use rates, demographic changes (population increases plus changes in age, sex, and income distribution) are projected to lead to a 10 percent increase by 1990 over 1975 demand, or 415,000 physicians in 1990 versus 378,000 in 1975.

Using a trend factor of increasing use based on 1968-1976 data, an additional increase of 185,000 in physician demand is projected.

Thus, the total projected demand for physicians in 1990 is 600,000 (415,000 plus 185,000).

Increases in demand attributable to a historical trend toward increased per capita use are overestimated, particularly for office services. The period 1968-1976 is used to establish the trend, but whereas a start date of 1968 yields a distinctly upward trend for physician office services, a start date of 1971 yields a downward trend (Figure 10).

Based on the Bureau of Health Manpower's model, an alternative approximation of the demand for physician services in 1990, adjusting only for demographic changes, and assuming no long term trend toward increases in per capita use, would be 415.00 physicians, an increase of 37,000 from 378,000 in 1975. But use could change, as could productivity. To some extent, these are policy choices to be made. If it is considered desirable for use to rise, for physicians to spend a few extra minutes with each patient, or for physicians to have shorter workweeks, much of the projected supply of 600,000 physicians in 1990 could be appropriate.

As supply is estimated to be 600,000 in 1990, there is a difference of 185,000 physicians between predicted supply and estimated demand in a static situation.

Some flexibility in the model is necessary, for several reasons. The enactment of national health insurance should lead to some increase in the demand for physician services. Second, physicians currently average longer workweeks than most of the rest of the labor force. Current projections are based on the assumption that physician productivity will remain constant to 1990, which, in specific terms, means that it is assumed that general surgeons will continue to average 52 hour patient care workweeks, pediatricians 50 hours, etc. If physicians continued to see patients at the same rate but shortened their workweek, this would have the effect of raising the number of physicians required to meet a specific level of demand for physician services. Alternatively, physicians might work the same number of hours, but see fewer patients and spend more time with each one. This would also raise the number of physicians required to meet a specific level of demand for services. According to the National Center for Health Statistics, almost half of all office visits to physicians in 1973 and 1977 lasted ten minutes or less. With smaller patient loads, physicians might be able to use the additional time to provide patients with more information, education, and counseling and lead to greater patient satisfaction with the quality of medical care.

It is therefore necessary to decide how much of these changes are desirable at the cost that will be borne by the society.

The GMENAC normative, medical opinion model estimates all diseases and conditions (on demographic bases such as age and sex) that should be treated by physicians and the amount of physician services, on a disease-by-disease or condition-by-condition basis, that should be provided.

The theoretical level of use is usually adjusted downwards to real-world estimates through consensus formation techniques. Instead of quantifying use by health care setting, these estimates quantify use on a specialty-by-specialty basis.

Unlike the Bureau of Health Manpower model, which can project demand year to year (projections now exist up to the year 2000), GMENAC's current future target is the year 1990, although its model is capable of providing year-to-year projections. GMENAC's modeling effort, because its ultimate aim is to provide recommendations on graduate medical education, professes to be less concerned with aggregate requirements. When addressed, aggregate requirements will be more of a byproduct of the parent GMENAC panel's consolidating the work of the individual specialty panels.

On the other hand, the Bureau of Health Manpower's model, as presently constructed, can only provide aggregate, and not specialty-specific physician requirements, because demand is grouped by health care setting, not by specialty care.

The normative, medical opinion model is thus, better capable of estimating specialty-by-specialty requirements but could overestimate aggregate physician requirements because of the difficulty of reconciling overlapping patient care responsibilities. This task is to be undertaken by the GMENAC panel after the work of its specialty panels is completed.

An unresolved issue, however, is the requirements for the primary care specialties. There are basic differences on what is primary care, disagreement over what specialties constitute the primary care ones, and the pragmatic problem that other specialists will continue to provide similar services even if there were agreement on what primary care is. The models cannot be expected to resolve these issues. Resolution of these issues is a pre-condition to projecting the requirements for primary care specialties.

The Bureau of Health Manpower's trend projection model and GMENAC's medical opinion, goal driven model are complementary, and not competing, models of estimating future physician requirements. As such, each model's results can aid in the interpretation of the other. Comparison of the models can shed some light on the relationship between medical need for physician services and trends in the actual use of those services. Ideally, the medical opinion model could be used to estimate the distribution of physicians by specialty within the aggregate requirements estimates provided by the BHM model.

The GMENAC model focuses on translating a normative definition of medical need into appropriate rates of use of medical services, while the BHM model looks on medical care as a "consumer good" and treats empirical trends in the use of medical services as a proxy for economic demand. If the BHM demand estimates should prove significantly greater than the GMENAC estimates, this would suggest that there are powerful factors at work that are pushing the use of medical services beyond the level medically necessary and appropriate for "good" care. This would then raise the policy question of what percentage of the projected future economic demand for medical services over and above the professional judgment-based estimates of medical need should be considered legitimate. Conversely, if the BHM demand estimates should prove significantly less than the GMENAC estimates, this would suggest that there remains and will remain in the near future significant barriers to obtaining medically necessary care for large segments of the American population rather than for a few discrete areas and populations. Presumably, these barriers could be financial, geographic, cultural, or involve ignorance about when to seek care -- most likely some mixture of these variables that would need to be investigated. Finally, if the BHM and GMENAC estimates prove to be in rough parity -- what could be viewed as the most desirable outcome -- this would suggest that the economic demand for services is more or less in line with professional estimates of the medical need for physician services.

As the GMENAC model has yet to generate any numbers, we cannot say which of these three alternatives will prove to be the case. We can say, however, that the most likely occurrence would appear to be rough parity or a BHM demand estimate that is significantly greater than the GMENAC aggregate estimate. The major reason for anticipating that the BHM estimate will most likely prove greater than or at least equal to the GMENAC estimate is that one of the major variables in the BHM model is a projected trend toward rising per capita use of medical services, independent of demographic changes and projected changes in price. In contrast, the GMENAC model assumes no major changes in medical need apart from changes in medical need induced by demographic shifts (e.g., an aging population) between now and 1990; hence, no medical rationale for large per capita increases in the use of physician services.

Estimates of locational requirements are used to address different problems than aggregate and specialty estimates. Such estimates are used in operating programs designed to provide physicians and other medical care resources to targeted populations. Thus, locational requirements are based not only on assumptions about what are appropriate types and quantities of medical services, but also on: (1) how medical services should be redistributed, and (2) the amount of care that the Federal government should provide or finance compared to other public and private sources.

These additional assumptions are clearly reflected in the designation and staffing ratios that were used to estimate the numbers of additional primary care physicians "needed" in shortage areas, and which, with additional criteria, provide the basis by which specific areas qualify as Health Manpower Shortage Areas.

> Designation ratio: The actual minimum ratio of active, non-federal, patient-care physicians engaged in primary care to the civilian population of an area below which an area is considered to have a shortage of health manpower sufficient to justify its being counted as a shortage area.
>
> Staffing ratio: The theoretical maximum ratio of active non-federal, patient-care physicians engaged in primary care to the civilian population of an area used as a standard above which an area is considered to have adequate health manpower so that additional Federal intervention with NHSC staffing is no longer necessary.

The designation ratio reflects that quarter of the U.S. having the least number of primary care physicians. It has been set at 1:3500. The staffing ratio establishes a limitation upon the extent of Federal involvement by specifying an "appropriate" relationship between the service demands of the population and the primary care physicians available to provide these services. It has been set at 1:2000.

Estimates of shortage areas in 1990 must be considered weak for a number of reasons. First, data on patterns of distribution of physicians aged 32 - 40 in 1974 are used as the base from which projections are made. These data are currently the most recent available. They reflect, however, the conditions and policies of the 1960s. To assume that physicians will continue to follow the same distributional patterns in 1990 is to discount the large increases in aggregate physician supply and deliberate policy efforts to increase the physician supply in shortage areas that have occurred since the 1960s. Second, future estimates are based almost entirely on county physician-to-population ratios, again due to limitations in available national data. Actual Health

Manpower Shortage Area designation, however, often involve smaller areas that have lower physician-to-population ratios than the county as a whole. Thus, methods for estimating future urban shortages are especially weak.

In such estimates, potential use divided by expected productivity (ultimately expressed in physician-to-population ratios) is an inadequate indicator of the targeted population's use of physician services, because average use and productivity calculated on a national basis can be expected to deviate from a specific population's use of specific physician services, and access problems (physical, financial, social) also determine whether use and productivity estimates are realized.

Thus, physician-to-population ratios comprise only part of the eligibility criteria that must be met to be designated a Health Manpower Shortage Area. Additional criteria include meeting specific definitions of "a rational area for the delivery of primary care services," and when "primary medical care manpower in contiguous areas are overutilized, excessively distant, or inaccessible to the population of the area under consideration."

Consequently, even if national aggregate and specialty requirements were satisfied, it would be unlikely that physicians would be evenly distributed in all geographic areas or equally accessible to all population groups. Thus, some areas would always be underserved as measured against the average national physician-to-population ratio.

Projections of supply and requirements depend on historical data to predict future events, but legislation in this area has purposely tried to affect physician specialty and location choices. Given the lag time between medical education and eventual practice, even recent historical data reflect past policies, not current ones.

As currently published, the projections of aggregate requirements from the Bureau of Health Manpower give no indication of the very different results that could be obtained by simply shifting the first years of the historical period used to establish the trend in per capita use from 1968 to 1971. Assumptions such as these are now hidden in the methodology, yet it is clear that they are crucial to the results.

Second, these estimates may be given in basic, high, and low projections or encompass a range of numbers, but they all revolve around the same set of assumptions. They are techniques that represent the degree of statistical confidence the methodologists have in their calculations, which is an entirely different question from projecting alternate estimates based on fundamentally different sets of assumptions about the factors that influence future supply and requirements.

The final and most important observation is that the forecasting process has remained too technical a process, where statistical techniques, economic knowledge, and medical expertise greatly influence the process. Yet, more often than not, the basic assumptions adopted in the methodologies are policy ones. This is particularly true for projections of the future supply of physicians and decisions on specialty distribution requirements. Further, policies that have been made and are under consideration directly impact on the projections, yet the reliance on historical data can systematically underestimate the effects of such policies. Methodologists themselves, in the absence of specific policy direction, are having to make decisions on which policies will most directly influence their projections. The result is that current forecasting techniques may influence policy decisions to a greater extent than called for.

Greater awareness of the limits of forecasting and less preoccupation with a particular set of numbers would be possible if the assumptions underlying the projections are made more explicit; alternative forecasts are projected, based on different sets of assumptions; and participation in the forecasting process is expanded to include policymakers as well as technicians.

FUTURE EXPENDITURES ON PHYSICIAN SERVICES: A Postscript to the report on Forecasts of Physician Supply & Requirements

From a supply of approximately 378,000 in 1975, the number of physicians is expected to reach nearly 600,000 in 1990. Accounting only for demographic changes, 1990 requirements were estimated at 415,000. The Bureau of Health Manpower (BHM) estimated that an additional 185,000 (or the rest of the expected supply) were "required," due to increasing per capita use of medical services. We questioned the magnitude of the increase, pointing out that a shift of the historical period used to set the trend for future per capita use from 1968 - 1976 to 1971 - 1976 (Figures 1 and 2) would offset the additional requirements. The BHM estimates also assumed constant productivity between 1975 and 1990. We also pointed out that requirements in addition to those reflecting demographic changes were highly sensitive to different assumptions about future per capita use and productivity.

What are the cost implications of these different estimates of future requirements for physicians? The cost in terms of annual medical care expenditures per physician has two components. First, there are the direct costs of the physician's services. This figure would include the physician's personal income before taxes plus professional expenses such as maintenance of an office and an office staff. Second, there are the indirect costs of revenues to the health system that a physician generates by admitting patients to hospitals and nursing homes, by ordering tests, prescribing drugs, and so forth.

For reasons that we will explain below, we believe that it is virtually impossible to come up with a responsible estimate that encompasses both direct and indirect costs per physician in 1990, but that it is possible to at least stake out the parameters of gross billings for physicians' services in 1990.

We will first outline what is known about current costs per physician and then address the question of cost estimates for 1990.

Total Costs Per Physician - Current Estimates

Two methods have been used to try to estimate the total costs — i.e., both in direct fees and indirect costs generated — that can be attributed on average to each practicing physician. One method involves collecting data on actual physician behavior. An estimate derived by this means is the often-cited figure of $250,000 per physician. This estimate, which dates from the early 1970's, originated with Princeton health economist, Uwe Reinhardt.[1] According to Professor Reinhardt the figure was derived from an analysis of records kept hy a group practice of internists in South Carolina. Of more recent vintage, a just-completed study of family practitioners in Richmond, Virginia, found that they generated an average of $1,789 in medical care costs daily.[2] Conducted by Blue Cross-Blue Shield and the Medical College of Virginia, the pilot study followed the physicians for one day, recording the costs of diagnostic tests ordered, hospital admissions, office procedures, medications, therapy services, and special consultations, in addition to physicians' fees. If we assume that family practice physicians work 5 days per week for 47 weeks per year, we arrive at a total annual average of $420,415 per physician.

The problem with both of these studies as a basis for making generalizations about the average physician is that they are based on extremely small samples. We have no idea, for example, how the costs of the procedures ordered by the Virginia physicians would compare with national cost averages for such procedures. Nor do we know how typical these physicians are in their practice behavior or whether their patient loads and case mixes are at all typical. Thus far, however, no ones seems to have done a similar study of actual physician practice behavior and costs generated, using a sample that could be considered scientifically representative.

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[1] Personal communication with OTA staff.

[2] American Medical News, February 29, 1980, p. 15.

The second method that is frequently used to estimate average costs generated per physician is what might be termed the statistical approach. Thus, if we have a statistic for a given year, estimating total national expenditures on hospital care, drugs, physician fees, and other medical costs physicians are considered responsible for generating, then we can simply divide that figure by the total number of physicians in active practice in that year to arrive at an average cost per physician. As an example of such an estimate: If we assume that physicians were responsible for generating 74 percent of total health expenditures in 1978, which would include besides physicians' services, the costs of all hospital and nursing home care as well as all drugs prescribed (Table 1), this would come to a figure of $142.5 billion worth of services. If there were 395,570 physicians estimated to be in active practice in 1978, then the average cost impact of each physician would have been roughly $356,250.

Unfortunately, even if we could be reasonably certain that such a figure were an accurate estimate of current average impact per physician on medical expenditures, it would not be scientifically valid to simply project that figure onto the 1990 supply of physicians. As Professor Reinhardt has pointed out with respect to the usefulness of his own often-quoted estimate for such purposes, what we really need to know to make future cost projections is the marginal impact of each additional physician to a given supply, under given conditions. Recall that the physician-to-population ratio in 1990 is expected to be roughly 242 per 100,000, as compared to 177 per 100,000 in 1975. Indeed, 40 percent of the physicians practicing in 1990 will have finished training and begun practicing after 1980. In view of such rapid expansion of the physician supply in relation to population growth, it would seem highly unlikely that the marginal impact of future additions to the physician supply could equal the current average cost impact per physician. To assume that each physician added to the current supply would add costs at the current average rate would necessitate making the assumption that there are no limits to the willingness or capacity of the individual American to consume additional medical services. This seems especially unlikely in view of a study by the Urban Institute, which found that physician-induced demand does exist, but that it is far from open-ended.

This research on physician behavior in response to the Economic Stablization Program for 1973 - 1974[3] suggests that, at least when their ability to raise fees is constrained, physicians can and do create increased demand by providing more intensive services. Physician-induced demand was found most likely to take the form of added followup visits or more intensive services per visit, primarily via prescribing additional diagnostic tests. It is quite important to note, however, that the extent of induced demand was found to be limited. Specifically, physicians did not induce sufficient demand to make up for the loss of income resulting from price controls. The authors did not speculate on what the observed limitation on demand creation was due to. They did conclude, however, that the evidence indicated that physicians either cannot or will not engage in open-ended demand creation sufficient to generate any income level they might choose to target.

Moreover, it is important to remember that, particularly in terms of physicians' impact on the medical costs of other than physicians' services, there are numerous constraints that come into play. For example, the supply of hospital beds is not expected to increase in proportion to the supply of physicians. Thus, it seems virtually certain that physicians in 1990 will be hospitalizing fewer patients on average than they do now.

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[3] Hadley, J., Holahan, J., and Scanlon, W., "Can Fee-for-Service Reimbursement Coexist with Demand Creation?" Inquiry 16:247-258 (Fall 1979).

Indeed, Jack Hadley of the Urban Institute has estimated that currently the marginal impact on total annual health care expenditures of adding one physician to the physician supply is about $70,000.[4] Hadley's estimate is based on a regression analysis using State data, where the dependent variable was total expenditures for medical care and the independent variables included numbers of physicians, extent of insurance coverage, supply of hospital beds, and population characteristics. Again, however, we cannot simply rely on Hadley's figure, which is based on current conditions, to predict 1990 expenditures and marginal impact per added physician. To do this we would need to know what the supply of hospital beds will be in 1990, whether or not there will be effective cost controls on medical procedures, the extent of insurance coverage among the population, and the average co-insurance rate. Thus, we lack the information needed to come up with a responsible estimate of marginal cost impact per physician in 1990 or an equation for projecting what total medical care expenditures generated by physicians are likely to be in 1990. What we can say, however, is that the signs (e.g., the slow rate of population growth, controls on hospital beds in relation to a rapidly-expanding supply of physicians) make it seem most likely that the marginal cost impact of additions to the physician supply will decrease considerably between now and 1990. Such a trend might be somewhat mitigated if enactment of a generous national health insurance program or some other demand-stimulating intervention were to occur.

While a decreasing marginal cost impact per addition to the physician supply would seem to have optimistic implications relative to what some have suggested might be the devastating cost implications of the greatly-increased physician supply in 1990, it is worth noting that this raises the question of whether all the physicians we expect will be trained in the next ten years can reasonably expect to have the same practice patterns and income as currently practicing physicians.

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[4] Personal communication with OTA staff.

Estimating the Direct Costs for Physicians' Services in 1990

To obtain an estimate of direct costs — that is, total billings for physician services in 1990 — is a simpler, more straightforward task than trying to estimate all physician-generated medical expenditures.

We start from the simple premise that physicians are no different from other Americans in that, given a choice, they would prefer to earn more from year to year, and, at the very least, to maintain their real income at its current level. Accordingly, we will answer the question: what would 1990 total expenditures be on physicians' services in order that the estimated 600,000 physicians earn as much as physicians currently earn?

The median practice income of office-based physicians in 1978 was $68,040.[5] Table 2 projects what their incomes would be in 1990 under a variety of assumptions concerning annual income increases and the relationship of physicians' incomes to the inflation rate. It should be noted that the inflation rate assumed in Table 2 is already outdated. A 7.7 percent average income gain per year was calculated to outpace inflation by one-tenth. But the predicted inflation rate of 7.0 percent actually turned out to be 13 percent in 1979. Further, the current Administration had assumed a 6.4 percent inflation rate for the fiscal year ending September 30, 1980. In January 1980, it was 18 percent. So none of the projections in Table 2 might even equal the rate of inflation; i.e., they all may represent real losses in income relative to 1978.

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[5] Farber, L., "Your Finances: Tactics to Put You Ahead of the Pack," Medical Economics, January 7, 1980, pp. 84-85.

The median gross income of office-based physicians in 1978 was $112,090,[6] for a ratio of net to gross income of 0.61. Assuming this ratio holds in the future, Table 2 also summarizes what the gross earnings of physicians would need to be to achieve the four alternative 1990 net income levels.

We can then make general estimates of expenditures on physicians' fees for the projected physician supply in 1990. However, some explanation is needed on the limitations of the use of office-based physicians' services.

Not all of the active physician supply would be providing patient care. On the other hand, those physicians not in patient care are nevertheless being paid, and hospital-based physicians can be expected to have higher incomes. So, in general, the use of office-based physicians' incomes is just as representative of average physician income as is any other category of physicians. In addition, in view of current rates of inflation, we now know that the percent income gains in Table 2 most likely underestimate what actually will occur.

We also have a means of making a rough estimate of the potential error factor. We can perform these calculations using the 1978 gross income figure and the 1978 physician supply and compare the results to the actual level of national expenditures on physician fees reported for 1978. Using an estimate of approximately 400,000 physicians in 1978 yields an estimated 1978 expenditure on physicians' services of $44.8 billion. The actual figure, according to preliminary estimates from DHEW, was $35.3 billion.[7] This estimate seems low, because it would average out at $88,250 gross revenues per physician. Nevertheless, we will reduce the $44.8 billion estimate of total physician expenditures by 20 percent and assume the same error rate in our 1990 calculations. The results are summarized in Table 3.

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[6] Owens, A., "A Financial Readout on the Family Practice Boom," Medical Economics, January 21, 1980, pp. 95-109.

[7] U.S. Department of Health, Education, and Welfare, Health United States 1979, Public Health Services, Office of Health Research, Statistics, and Technology, DHEW Publications No. (PHS) 80-1232, p. 238.

Recall that the Bureau of Health Manpower estimates of physician requirements in 1990 equalled the estimated supply; i.e., both were for 600,000 physicians. But the 185,000 attributed to rising per capita use is in dispute, so Table 3 also disaggregates total physician expenditures into requirements attributed to increases in the population and changes in its age, sex, and income level distributions and those increases attributed to rising per capita use. The amount in dispute is quite significant, equalling 31 percent of total expenditures on physician services, or from 27.0 to 40.2 billion dollars.

How likely is it that physicians will be able to maintain or improve their real annual net income? As the above figures indicate, physicians (and everyone else) must increase their total billings (gross income) even to stay *behind* the inflation rate. There are only two ways for physicians to increase billings; they can raise their fees or they can provide more services. Historically, they have done both. On the latter point, physicians can provide more services either by taking on more patients or by providing more services per patient.

But increases in the physician supply are greatly outpacing population growth; the physician-to-population ratio increases from 177/100,000 in 1975 to 242/100,000 in 1990. Hence, servicing larger numbers of patients is not an option for the majority of physicians. We may already be seeing this phenomenon. Per capita physician visit rates have tended to stabilize during the 1970's (Figure 1), though the physician visit rate of low income persons did increase moderately (following the dramatic gains made immediately after the introduction of Medicare and Medicaid in the late 1960's).

Again, from *Medical Economics* magazine's Continuing Survey:

> Back in the mid-60s, when Medicare and Medicaid started, unincorporated

> doctors were seeing patients at an average rate of 124 a week. Spurred by the new demand for services, they raised that figure to 137 by 1970, then started on the current downhill path. Already this has taken them well below the pre-Mediplan level to 116 visits per week. Similarly, incorporated M.D.s have been seeing an average of a dozen fewer patients a week than in 1970.[8]

These figures suggest that the growth in physician supply over the past decade has been more than sufficient to accomodate increases in demand. Indeed, it is interesting to note that declines in patient visit rates have mainly affected those specialties that have experienced the greatest growth. From 1974 to 1978, for example, median weekly patient visit rates per family practitioner dropped from 200 to 171. General practitioners and pediatricians have also shown declines in weekly patient visits. However, internists have shown a slight increase, a median increase of 3 patient visits per week over the 1974 - 1978 period.[9]

These figures raise the question of whether the shortage in primary care physicians is really as acute as is commonly believed. But a primary care physician shortage may exist if we assume that factors other than physician supply per se (such as high out-of-pocket costs to the patient) are at work keeping the demand for their services unnaturally low. It would, however, be necessary to remove such demand depressants in order for any shortage in the supply of primary care physicians relative to true demand or medical need to surface.

To return to the question of costs, the trade-off relationship between rising fees and provision of more services in relation to physician income is evident in the data from the Medical Economics Continuing Survey.

> ...Despite rising costs, median practice earnings after expenses

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[8] Owens, A., "What's Behind the Drop in Doctors' Productivity?" Medical Economics, July 24, 1978, p. 102.

[9] Owens, A., "A Financial Readout on The Family Practice Boom," Medical Economics, January 21, 1980, pp. 95-109.

> increased 24 percent in the three years ending with 1976. During the same period, patient visits per doctor per week dropped nearly 4 percent.
>
> The explanation? A three-year rise of 39 percent in physicians' fees, according to the Consumer Price Index. Had doctors' productivity as measured by patient visits not gone down during that period, fee boosts might have been held to no more than the 26 percent increase in the over-all cost of living...
>
> An early reversal of the present downtrend in physician productivity would benefit both the public and the profession. That a good many doctors are capable of boosting their patient-visit rates is evident from the survey finding that some are currently seeing up to six times as many patients a week as others in the same specialty and type of practice. And an increase of just 10 visits per week, on average, not only would restore the relatively high productivity level of 1974 but also would raise doctors' incomes enough to offset inflation in the next year without fee increases.[10]

However, in order for physician productivity to increase in the face of rising physician-to-population ratios, Americans must use more physicians' services per capita. At present, the only way to stimulate increases in patient demand for services would seem to be via national health insurance or some other mechanism for decreasing patients' out-of-pocket expenses. An alternative means of increasing the use of physicians' services is for physicians to induce demand.

The issue of physicians' ability and willingness to induce demand for additional services is a controversial one. But we have seen from the Urban Institute's study of physician behavior during the 1973 - 1974 price freeze that, although physicians did respond to declines in their real incomes by providing more intensive services to Medicare patients, the extent of the induced demand remained limited, and they could not or would not induce sufficient demand for their services to compensate for the decline in real income brought about by the price freeze.

In conclusion, unless national health insurance or some other factor intervenes to greatly stimulate per capita use of physicians' services, the most likely result of rising physician-to-population ratios will be declining physician productivity and sharply rising fees for physicians' services. Rising fees will increase total expenditures -- as will the sheer numbers of physicians coming on the scene -- but may still be insufficient to keep physicians' incomes on a par with the inflation rate. In brief, there is a substantial likelihood that the nation will have to pay considerably more to maintain the same or a slightly higher per capita rate of consumption of medical services. Yet, at the same time, the physician's real income will have declined.

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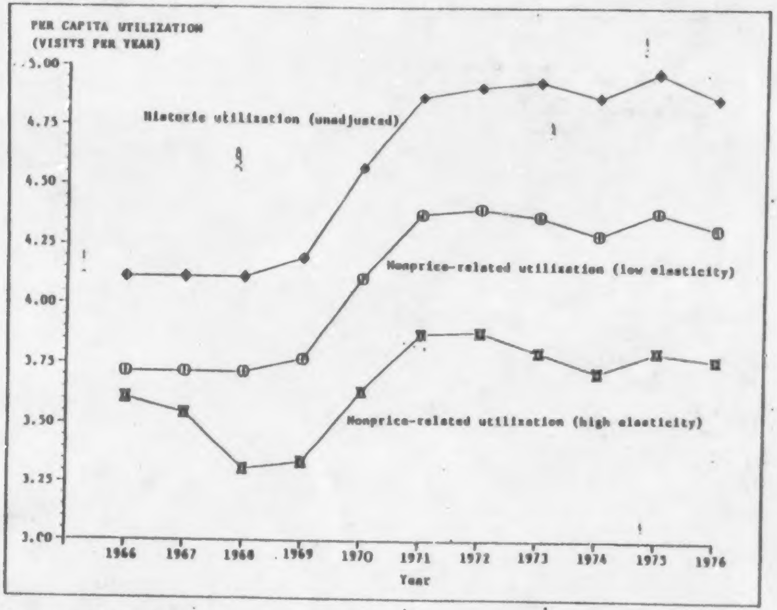
[10] Owens, A., "What's Behind the Drop in Doctors' Productivity?" Medical Economics, July 24, 1978, pp. 102-105.

Figure 1

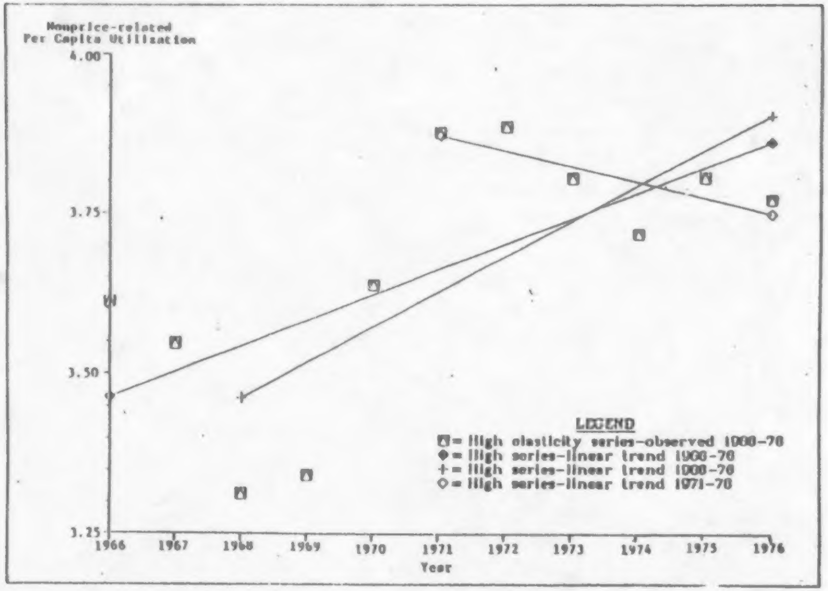
Per Capita Utilization of Physician Office Services, 1966 - 1976



Source: JWK International Incorporated, 1979, Evaluation of Project SOAR (Supply, Output, and Requirements), draft report, DHEW Contract No. HRA 232-78-0140.

Figure 2

Nonprice-Related Per Capita Utilization Trends, Physician Office Services, 1966-1976



Source: JWK International Incorporated, 1979, Evaluation of Project SOAR (Supply, Output, and Requirements), draft report, DHEW Contract No. HRA 232-78-0140.

Table 1

National Health Expenditures and Percent Distribution, According to Type of Expenditures, United States, 1978 (estimated)

Type of Expenditure	Percent	
Health Services and Supplies	95.1	
Hospital Care	39.5	
Physician Services	18.3	
Dentist Services	6.9	
Nursing Home Care	8.2	
Other Professional Services	2.2	
Drugs and Drug Sundries	7.9	
Eyeglasses and Appliances	2.0	
Expenses for Prepayment	5.2	
Government Public Health Activities	2.6	
Other Health Services	2.3	
Research and Construction	4.9	
Research	2.2	
Construction	2.7	
Total	100.0	$192.4 billion

Source: U.S. Department of Health, Education, and Welfare, Health United States 1979, Public Health Service, Office of Health Research, Statistics, and Technology, DHEW Publication No. (PHS) 80-1232, Table 73, p. 252.

Table 2

Projected Income of Office-Based Physicians to 1990 from 1978 Base

1978 Median Pre-Tax Income	Average Income Gains per Year	Projected 1990 Net Income	Projected 1990 Gross Income[a]
$68,040	4.2 % (average gain '76-'78)	$111,470	$182,738
1978 Median Gross Income	6.4% (1970's pace)	$143,240	$234,820
$112,090	7.0% (keeping pace with moderate inflation)	$153,240	$251,213
	7.7% [b] (outpace inflation by one-tenth)	$165,710	$271,656

Source: Farber, L. "Your Finances: Tactics to Put You Ahead of the Pack," Medical Economics, January 7, 1980, pp. 84-85; Owens, A., "A Financial Readout on the Family Practice Boom," Medical Economics, January 21, 1980, p. 109.

[a] Assuming same ratio as between 1978 median pre-tax and gross incomes.

[b] Actual 1979 rate of inflation was 13 percent.

Table 3

Projected 1990 Expenditures on Physicians' Services, Assuming Different Growth Rates of Gross Income (1978 Gross Income of $112,090)

Annual Growth Rate	Median Gross Income	Total National Expenditures[a]	Expenditures on Number of Physicians Required (Physician Productivity Assumed Constant)		
			Demographic Changes[b]	plus	Increased Per Capita Use[c]
4.2%	$182,738	$87.7 billion	$60.7 billion		$27.0 billion (31% of total expenditures)
6.4%	$234,820	$112.8 billion	$78.0 billion		$34.8 billion
7.0%	$251,213	$120.6 billion	$83.4 billion		$37.2 billion
7.7%	$271,656	$130.4 billion	$90.2 billion		$40.2 billion

Source: see text.

[a] Assumes a physician supply of 600,000 in 1990.

[b] Adds 37,000 physicians to the 1975 base of 378,000 for a total of 415,000 to account for increased population growth and changes in the population's age, sex, and income level distribution.

[c] Adds an additional 185,000 physicians, based on the Bureau of Health Manpower's estimate of increased per capita use. See text for counterargument.

ADVISORY PANEL ON

TECHNOLOGIES FOR ESTIMATING PHYSICIAN SUPPLY & REQUIREMENTS

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School of Medicine
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Mr. **Waxman**. Thank you, Dr. Hadley?

STATEMENT OF JACK HADLEY, PH. D.

Dr. **Hadley**. Thank you, Mr. Chairman.

My name is Jack Hadley. I am most grateful for the opportunity to appear before you this morning.

I would like to discuss the issue of physician created demand, that is physicians' alleged ability to convince people to increase their use of medical care without having to lower the price charged.

Many policymakers are concerned that demand creation coupled with the projected large increase in the number of physicians will lead to unacceptably high expenditures for physician's services. I believe that concern about demand creation per se may be too strong and as a result may mask other important issues, the existence of alternative ways to limit expenditures and the possibly beneficial increases in access to care that might accompany an increased supply of physicians.

In order to assess the importance of demand creation I would like to report some data on trends in physicians' incomes in the United States and Canada. Both countries have experienced high rated of general price inflation and high rates of increase in the number of physicians.

If these factors represent threats to physicians' real incomes then we would expect physicians to use demand creation to buttress their economic positions under these conditions.

Let me summarize the data in my written statement. Between 1970 and 1978 physician's real incomes in the United States did not increase at an extraordinary rate. Physicians in some specialties suffered declining real incomes. The data from Canada also show that physician's real incomes declined in the years following implementation of national health insurance in each Canadian province.

In order to interpret these data let me note that expenditures for physician's services can be decomposed into four components; the number of patient visits; the number of distinct medical services provided per visit; the mix or complexity of the services and the price charged for each service.

Increases in any of these factors will lead to increases in expenditures. However each also has different implications for policies to limit costs or to improve access to care.

What can be inferred from the data on trends in physician's incomes? First it seems fairly clear that physicians' ability to increase their real incomes is not extraordinary. This suggets that either physicians are very civic minded and have decided to join the battle against inflation by choosing not to increase their real incomes or alternatively the overall quantitative impact of demand creation is limited.

Second, the pattern of declines and increases in different specialties' incomes is closely related to each specialty's ability to provide more services per visit or a more complex mix of services.

The specialties which had the biggest drops in real incomes, general practice, pediatrics, and psychiatry, have the least opportunity to incorporate additional tests and additional procedures into their practices.

Third, pure price increases are also a major factor in the growth of expenditures for physicians' services.

Fourth, the Canadian experience suggests that high rates of the growth in physician supply do not inevitably mean that ever larger shares of the gross naitonal product will be devoted to paying for physicians' services.

What other consequenes might we expect from the projected increases in the supply of physicians in the United States? First there is a growing body evidence that the increasing supply is pushing more and more physicians into smaller communities.

Second, as competition among physicians for privately insured patients becomes more intense physicians may become more willing to treat people eligible for medicaid and to accept assignment for medicare patients.

Third, should there be a major expansion of insurance coverage through either expansion of medicare and medicaid or passage of a comprehensive national health insurance plan, the increased physician capacity may be essential to meet new demands for care without setting off an additional inflationary spiral in medical care prices.

Fourth, finding physicians to staff public hospitals and clinics, other public medical care program programs and correctional institutions should become easier.

Last, future physicians facing less rosy fiscal prospects than their predecessors may be much more responsive to any number of possible financial incentives which could be built into public financing programs.

In conclusion, more physicians clearly means more physicians' services. If is is determined that the Nation will have more medical services than it needs than attempting to reduce the future supply may be warranted. If the primary concern is with expenditures rather than services then I suggest that focusing policy attention on the pricing side of the equation might be as important if not more so than trying to turn back the clock on physician supply.

In particular we may be able to both improve access and limit costs if methods can be developed to limit price increases, to simplify procedure coding systems, and to limit access to costly new medical technologies.

Continued efforts to shift more physicians into primary care specialties if successful will also have beneficial cost implications.

I have brought with me, Mr. Chairman, copies of several papers which I would like to submit for the record and for distribution among the subcommittee members and their staffs.[1]

Thank you again for the opportunity to appear before you.

[Testimony resumes on p. 771.]

[Dr. Hadley's prepared statement follows:]

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[1] The papers referred to by Dr. Hadley may be found in the subcommittee files.

STATEMENT OF

Jack Hadley, Ph.D.
Senior Research Associate
The Urban Institute

Thank you Mr. Chairman. My name is Jack Hadley. I am an economist with the Health Policy Program of The Urban Institute, a nonprofit research organization located here in Washington. I am most grateful for the opportunity to appear before you this morning.

I would like to discuss the issue of physician-created demand, i.e., physicians' ability to convince people to increase their use of medical care without having to lower the price charged. Many policymakers are concerned that demand creation coupled with the projected large increase in the number of physicians will lead to unacceptably high expenditures for physicians' services. I believe that the concern about demand-creation per se may be too strong and, as a result may mask other important issues--the existence of alternative ways to limit expenditures and the possibly beneficial increases in access to care that might accompany an increased supply of physicians.

The concept of physician-created demand or demand-inducement refers to physicians' alleged ability to shift patients' demand for medical care at a given price, that is, to convince patients to increase their use of medical care without having to lower the price charged. (Equivalently, physicians may persuade patients not to reduce the quantity of care purchased in response to a price increase.) By demand, I mean the quantity of medical care patients are willing to purchase at various prices, holding constant the effects of insurance coverage, the time costs of obtaining medical care, the quantity of care, patients' health status, income level, education, and similar factors.

The ability to create demand is based on the fact that patients generally lack the medical knowledge required to assess the quality, efficacy, and need for medical care. Consequently, the patient's physician takes on the dual role of medical care adviser and provider. In general, the patient is in a poor position to argue with the physician's recommendations and, in fact, frequently is exhorted to "follow doctor's orders." This tendency is reinforced further by extensive insurance coverage that reduces the patient's fiscal incentive to say no.

Given this scenario, it has been argued that if physicians' incomes are threatened by some disequilibrating event, for example, by a large increase in the number of physicians per capita, then they will take corrective measures by exercising their demand-creation powers. Rather than lowering prices to attract additional patients, as a standard economic model would predict, the physician raises prices to make up for lost revenues. Further, per capita utilization of medical services goes up because of physicians' influence over patients' decisions. As Dr. Banta pointed out in his testimony, if future physicians desire simply to maintain the real incomes being earned by current practitioners, then this implies a doubling or possibly tripling of expenditures for physicians' services.

In order to assess the importance of demand creation, I would like to report some data on trends in physicians' incomes in the U.S. and in Canada. Both countries have experienced high rates of general price inflation and high rates of increase in the number of physicians. If these factors represent threats to physicians' real incomes, then we would expect them to use demand creation to buttress their economic positions under these conditions.

First, what has happened to physicians' net incomes between 1970 and 1978? Over this period, the number of physicians per capita increased from 147 to about 190, that is, at a rate of about 3.6 percent per year. Between 1978 and 1990, the rate of increase is expected to be about 2.3 percent per year. Thus, the recent past may provide some reasonable approximations for changes in physicians' activities.

For all physicians, real net income per physician from medical practice increased at a rate of 1.32 percent per year. Furthermore, between 1970 and 1973, a period dominated by the Economic Stablization Program, real income increased by only about 0.5 percent per year. Although physicians' income growth has been more rapid than for most Americans, it should be noted that nonsupervisory workers in manufacturing industries increased their earnings over the full eight-year period at a rate of about 1.41 percent per year.

These figures are of course averages for physicians in all specialties. Income data are also available for 1970 and 1978 for general practitioners, internists, pediatricians, obstetrician-gynecologists, and psychiatrists. On average, physicians in each of these specialties suffered a decrease in real net income over this period. (See Table 1.) For obstetrician-gynecologists, the decrease was just under one percent; for psychiatrists, it was almost 20 percent. Since average real income has gone up for all physicians, this can only mean that real income gains by general surgeons, surgical specialists, and the hospital-based specialties (radiology, pathology, anesthesiology) more than offset the real income decreases I just mentioned.

Other evidence on the strength of physicians' ability to create demand can be drawn from experience in Canada. We were interested in what happened to expenditures for physicians' services and physicians' real net incomes in each province following adoption of universal, comprehensive health insurance systems with no coinsurance or deductible provisions. We examined data for the four years following conversion to the new insurance system, but excluded the transition year from our calculations. (See Table 2.) Expenditures for physicians' services increased at positive annual rates for every province but one. However, these rates were lower than the rates of increase in the four years preceeding implementation of the insurance plans. The rates of expenditure increase were also only about half as large as rates of increase in the supply of physicians. Thirdly, physicians' incomes declined in every province at rates ranging from 2.37 to 6.56 percent per year.

It is also interesting to compare the shares of gross national product (GNP) devoted to physicians' services in Canada and the United States. In 1971, just after the last Canadian province had fully implemented its insurance plan, Canada spent 1.31 percent of its GNP on physicians' services and the United States 1.41 percent. By 1976, the Canadian share has fallen to 1.09 percent while the U.S. share had grown to 1.75 percent. Over this period, the number of physicians per capita grew by 17.2 percent in Canada and by 5.2 percent in the U.S. (See Table 3.)

Table 3

Expenditures for Physicians' Services as a Percent of GNP, Canada and U.S. 1960-1976

	1960	1965	1970	1971	1972	1973	1974	1975	1976
Expenditures for physicians' services as a % of GNP									
Canada	0.93%	0.98%	1.20%	1.31%	1.31%	1.19%	1.12%	1.15%	1.09%
United States	1.14	1.37	1.36	1.41	1.49	1.43	1.41	1.69	1.75
Active physicians per 100,000 population									
Canada	81	84	93	99	104	106	110	114	116
United States	137	143	147	154	154	154	156	159	162

Sources: Canadian Medical Association, Statistics, Systems and Economic Research Unit, *Quickbase* (February 1977).
"National Health Expenditures" *Social Security Bulletin* (selected issues).
Health and Welfare Canada. "Earnings of Physicians in Canada, 1953–1973," and unpublished data. Population data from Statistics Canada.
U.S. Department of Health, Education, and Welfare, *A Report to the President and Congress on the Status of Health Professions Personnel in the United States*, DHEW Publication No. (HRA) 79-93, August 1978. Population data from *The United States Statistical Abstract*, 1978.

In order to interpret these data, let me note that expenditures for physicians' services can be decomposed into four components:

- the number of patient visits,
- the number of distinct medical services provided per visit,
- the mix or complexity of the services,
- the price charged for each service.

Increases in any of these factors will lead to increases in expenditures, ceteris paribus. However, each also has different implications for policies to limit costs or to improve access to care.

What can be inferred from the data on trends in physicians' incomes? First, it seems fairly clear that physicians' ability to increase their real incomes is not extraordinary. In fact, some physicians have experienced declines in real incomes. This suggests that either physicians are very civic minded and have decided to join the battle against inflation by not increasing their real incomes, or, alternatively, the overall quantitative impact of demand creation is limited.

Second, the pattern of declines [illegible] increases in different specialties' incomes is closely related to each specialty's ability to provide more services per visit or a more complex mix of services. The specialties which had the biggest drops in real incomes, general practice, pediatrics, and psychiatry, have the least opportunity to incorporate additional tests and additional procedures into their practices.

Third, we know from other data that annual hours of work have remained essentially constant, that the weekly patient load has declined slightly, and that prices measured by the physicians' fee component of the Consumer

Price Index, have increased sharply, by about 55 percent between 1970 and 1976. Thus, pure price increases are also a major factor in the growth of expenditures for physicians' services.

Fourth, the Canadian experience suggests that high rates of growth in physician supply do not inevitably mean that ever larger shares of the gross national product will be devoted to paying for physicians' services.

What other consequences might we expect from the projected increases in the supply of physicians in the United States? First, there is a growing body of evidence that the increasing supply is pushing more and more physicians into smaller communities. Thus, efforts to redistribute physicians geographically should be enhanced.

Second, as competition among physicians for privately insured patients becomes more intense, physicians may become more willing to treat people eligible for Medicaid and to accept assignment for Medicare patients. Although increased access by these programs' beneficiaries means higher program costs for physicians' services, these costs should be offset to some extent by lower use of hospital ambulatory care facilities.

Third, should there be a major expansion of insurance coverage through either Medicare and Medicaid reform or passage of a comprehensive national health insurance plan, the increased physician capacity may be essential to meet new demands for care without setting off an additional inflationary spiral in medical care prices.

Fourth, finding physicians to staff public hospitals and clinics, other public medical care programs, and correctional institutions should become easier.

Finally, future physicians facing less rosy fiscal prospects than their predecessors may be much more responsive to any number of possible financial incentives which could be build into public financing programs.

In conclusion, more physicians clearly means more physicians' services. If it is determined that the Nation will have more medical services than it needs, then attempting to reduce the future supply may be warranted. If, however, the primary concern is with expenditures rather than services, then I suggest that focusing policy attention on the pricing side of the equation might be as important, if not more so, than trying to turn back the clock on physician supply. In particular, we may be able to both improve access and limit costs if methods can be developed to limit price increases, to simplify procedure coding systems, and to limit access to costly new medical technologies. Finally, continued efforts to shift more physicians into primary care specialties, if successful, will also have beneficial cost implications.

I have brought with me, Mr. Chairman, copies of several papers which I would like to submit for the record and for distribution among the Subcommittee members and their staffs.

Thank you again for the opportunity to appear before you.

Mr. **Waxman**. Thank you very much.

The studies both of you have talked about indicate each practicing physician generates on the average about $300,000 in total health care costs. What happens when the physician to population ratio increases? Do the additional physicians provide additional services and do the aggregate costs increase and by how much?

Dr. **Banta**. Let me give a general answer and Dr. Hadley can give a more technical answer.

Certainly each physician does carry a degree of overhead with him, but at the same time there is a limitation on how much that overhead is. For example, the number of hospital beds is now falling in this country. It is not therefore possible to expand the number of hospitalizations in this country despite an expansion in the number of physicians.

These factors make it very difficult in my opinion to make any sort of a hard and fast estimate but it surely will be more than just the income of those physicians themselves.

Dr. **Hadley**. I would like to add that simply increasing the supply of physicians without making changes in other parts of the system would probably reduce the average impact of future physicians below what it is today.

There are many factors that ultimately determine total expenditures. I think we just do not know very well how those things will change. My hunch is that the simple average expenditure that we compute today is probably an overestimate of what the impact will be of additional future physicians.

Mr. **Waxman**. What happens to fees when there are many physicians in an area? Do fees go up or down?

Dr. **Hadley**. There is a fair amount of controversy on that question. Simple correlations between price levels or fees and the availability of physicians suggest the fees are higher where there are more physicians.

More technical studies indicate there may be some moderating influence with an increase in the number of physicians but the magnitude of that effect is probably quite small. If anything a large increase in the supply of physicians might lower the rate of increase in fees but probably not make it decline or become negative.

Dr. **Banta**. I think that Dr. Hadley made a very important point in his statement about the difference between different specialties, what has been called procedure medicine.

Mr. **Waxman**. I noticed the specialties that do have the biggest drop in real income; general practice, pediatrics, and psychiatry. They also have the least opporunity to incorporate additional tests and additional procedures.

Dr. **Banta**. Exactly. I would like to give a very concrete example of the problem our present reimbursement system gives. The example is gastrocopy, which is passing an endoscope into the stomach to visualize it. We have had a contract to estimate the cost of providing that procedure in a physician's office, including the physician's time. The estimate is about $41.

The Blue Shield reimbursement in California for that procedure is $240. The gastroenterologist can easily expand his income by doing more gastroscopies, whereas the family practitioner does not have that as an option, generally speaking.

One would assume there is a limit to how many patients will accept a gastroscopy.

Mr. **Waxman**. That is one restraint on the ability of physicians to create demand. What other restraints are there?

Dr. **Hadley**. I think the biggest one is that there are still many people who do not have complete insurance coverage. As long as there is some element of out-of-pocket costs associated with going to a physician then it will become increasingly more difficult to attract more patients.

I think the safety valve for some physicians is, as Dr. Banta and you have mentioned, the ability to develop new procedures and to provide additional tests. That ability varies quite a bit from specialty to specialty.

Mr. **Waxman**. Do you completely discount professional ethics?

Dr. **Hadley**. No, sir.

Mr. **Waxman**. Economists have trouble measuring it.

Dr. **Hadley**. That is true.

Dr. **Banta**. As a physician I certainly do not discount professional ethics. The problem is, faced with an individual patient, the physician finds it very easy to justify an additional procedure. If the patient visit is insured, the cost to the patient may be zero and the benefit may be very small but real.

I think it is easy for an ethical physician to justify doing another procedure.

Mr. **Waxman**. What about the volume of services when we find there are many physicians in an area? Will areas with many physicians have higher utilization levels?

Dr. **Hadley**. The data show the number of patients seen is lower but the average expense per patient is higher in areas with large supplies of physicians. While it is a little bit hard to unravel exactly what that means, the presumption is that patients in well doctored areas have longer visits and have more tests done per visit and more diagnostic procedures per visit.

Whether that means better quality medicine and what effect that has on outcome, I think it is difficult to say. Conversely in rural areas physicians see many more patients for less time per patient.

Mr. **Waxman**. I understand Dr. Wennberg and others have associated surgical utilization rates with the number of surgeons in an area. Dr. Banta, can you comment on that?

Dr. **Banta**. Yes, sir. That is correct. Dr. Wennberg has looked at small areas in New England and has shown that the rate of such surgical procedures as tonsillectomy and hysterectomy does not sem to have any relation to the need for those procedures. One would asume a base need but the number of procedures is related to the number of surgeons in those areas.

That has also been shown internationally in comparison between England, Canada, and the United States. The rates of surgery are proportionately related to the number of surgeons that each of those three countries have.

We have the largest number of surgeons in this country and we also have the highest rate of surgery.

Table 1

Physicians' Net Incomes by Specialty, Current and Real Dollars, 1970 and 1978

	Current Dollars		Real Dollars (1967 = 100)		Percentage Change in Real Incomes 1970-78
	1970	1978	1970	1928	
General Practice	$33,859	$51,030	$29,113	$26,116	-10.3
Internal Medicine	40,251	66,140	34,610	33,848	- 2.3
Pediatrics	34,799	51,480	29,922	26,346	-12.0
Psychiatry	39,896	53,790	34,304	27,528	-19.8
Obstetrics-Gynecology	47,094	78,420	40,494	40,133	- 0.9
All Specialties	41,789	77,600	35,932	39,713	+10.5

SOURCES: 1970: American Medical Association, Profile of Medical Practice. 1978: Medical Economics.

Table 2

Annual Compound rates of Growth (Percent Per Year) in Physicians' Net Income, Population of Physicians, and Expenditures on Physicians' Services by Canadian Province, Before and After Medicare (Canadian National Health Insurance), 1958-1976*

	ALB	BC	MAN	NB	NF	NS	ONT	PEI	QUE	SAS**
Date Medicare implemented	July 1, 1969	July 1, 1968	Apr. 1, 1969	Jan. 1, 1971	Apr. 1, 1969	Apr. 1, 1969	Oct. 1, 1969	Dec. 1, 1970	Nov. 1, 1970	July 1, 1962
Transition year	1970	1969	1969	1971	1969	1969	1970	1971	1971	1963
A. Net MD incomes *(1970 dollars)*										
Pre-Medicare	4.78%	1.10%	2.97%	2.64%	2.63%	2.24%	2.82%	1.70%	0.55%	−2.42%
Post-Medicare										
Includes transition year	−4.90	−1.57	−1.63	−6.41	−2.46	0.80	−5.62	−7.46	−5.77	−2.33
Excludes transition year	−5.70	−2.37	−6.21	−6.56	−3.62	−3.16	−6.15	−5.20	−4.92	−3.74
B. Physician population										
Pre-Medicare	9.92	9.62	5.74	10.59	9.92	8.95	7.70	7.20	7.07	2.34
Post-Medicare										
Includes transition year	5.52	8.34	5.78	8.96	7.53	8.44	5.71	5.47	8.90	6.30
Excludes transition year	5.10	8.06	4.11	5.77	5.63	6.05	4.70	6.10	5.87	4.05
C. Expenditures *(1970 dollars)*										
Pre-Medicare	13.35	8.67	5.89	8.65	10.31	7.55	9.49	7.56	5.00	N/A
Post-Medicare										
Includes transition year	3.41	6.61	4.57	3.13	5.30	9.11	3.23	0.22	3.42	2.62
Excludes transition year	2.41	5.78	−0.82	0.51	0.93	3.59	1.74	4.46	2.08	2.13

* Four-year periods, before and after implementation of Medicare in each province.

** Complete names of provinces follow:

ALB—Alberta
BC—British Columbia
MAN—Manitoba
NB—New Brunswick
NF—Newfoundland
NS—Nova Scotia
ONT—Ontario
PEI—Prince Edward Island
QUE—Quebec
SAS—Saskatchewan

Sources: Health and Welfare Canada, *Earnings of Physicians in Canada*, and unpublished statistics from Health and Welfare Canada.

Mr. **Waxman**. Would you explain that in the same way you would justify physicians considering legitimate procedures that may end up costing a patient nothing but has some value?

Dr. **Banta**. Let me take a hysterectomy as an example. A hysterectomy is certainly indicated for a woman who has cancer of the uterus, severe bleeding from the uterus or some similar life threatening condition. A hysterectomy is done very much these days for contraceptive purposes or because of fear of cancer.

It is very difficult to say that doing a hysterectomy because a woman is very afraid of becoming pregnant is unethical and it is also very difficult to say the physician is doing it because of additional income.

One study in California showed physicians' wives had a higher rate of hysterectomies than the general population.

There is apparently faith in this kind of procedures, although I think that there is an overuse. I do not think it is strictly because of economic factors.

Mr. **Waxman**. If we then change the reimbursement system, are you convinced that is going to lower the utilization that we see and the amount of surgery we see?

Dr. **Banta**. I think it will. I will let the economists talk about the margin. But at the margin the physician is deciding what to do. I believe if the physician is paid more for counseling the patient and less for doing technological procedures, there will be a shift in the direction of counseling the patient and away from the more technological procedures. These are discretionary services.

Mr. **Waxman**. Does the faith and belief in certain kinds of services become modified by the economic incentives?

Dr. **Banta**. I think that is well stated.

Dr. **Hadley**. It certainly is reinforced by the reimbursement system. I think with regard to surgery it is the case that in the long run the impact of altering relative rates of reimbursement will be to change the relative attractiveness of becoming a surgeon as opposed to a family practitioner or a general practitioner.

In the short run there is a lot of interspecialty crossover in terms of large numbers of physicians that do procedures on only an occasional basis. I think that it is among those physicians that one would first see cutbacks in the frequency of doing these procedures for which relative payments might be reduced.

I think there is a growing body of evidence that physicians in fact respond to financial incentives much like any other businessman or professional. I do not mean to demean that behavior at all, but just to say that I think reimbursement can be used to influence the pattern of medical care.

Mr. **Waxman**. Our reimbursement system now reimburses higher for services in urban areas where there are already many physicians per population and lower in areas where there is a lesser number of physicians or those areas that are called underserved areas.

Dr. **Hadley**. That is correct.

Mr. **Waxman**. Do you feel the reimbursement system is having an impact on the geographical distribution of physicians?

Dr. **Hadley**. I think so most emphatically. I recently completed a review of eight economic studies on the factors that influence physicians' location choices. They almost unanimously indicate that expected income or the ability to have a viable practice are important determinants of the number of physicians in an area. In general, these factors are highly correlated with the rate of reimbursement in an area.

I suspect modifying reimbursement to change incentives and to make locations in underserved areas more financially attractive would have a strong reinforcing effect on trends that we now observe.

Mr. **Waxman**. If we increase the aggregate number of physicians would the sheer numbers have an impact on better distribution?

Dr. **Hadley**. It does but I think it is a very slow process and it is one that could be greatly enhanced by altering relative reimbursement rates. Over the last 5 or 6 years there is growing evidence that physicians are already beginning to spill over into smaller communities and away from the large urban centers.

Mr. **Waxman**. Will an increase in the aggregate number of physicians have any impact on the specialty distribution problem?

Dr. **Hadley**. I think that is a little less clear cut. Under the existing reimbursement system there is still a lot of give and a lot of flexibility in terms of the ability to absorb more physicians into specialties. My feeling is that the specialty choices of some physicians are sensitive to financial incentives. In other words, you do not have to change everybody's behavior to move in the direction you want to go. There are probably many physicians in training now who are on the borderline between deciding to specialize in family practice or a medical subspecialty. Altering reimbursement rates would probably influence the decisions of those physicians.

Dr. **Banta**. There is a lot of concern in some specialty societies—American College of Surgeons comes particularly to mind—about having too many physicians in that particular specialty. We already have a situation where the specialty societies and the specialty training programs are very sensitive about the numbers. I do not think they are going to expand their numbers very greatly because of their own concern.

Mr. **Waxman**. What is the nature of their concern?

Dr. **Banta**. Particularly in the general surgery area. The studies which I cited of other countries and the one you brought up of rates within this country have stimulated the American College of Surgeons to do its own study. They have concluded that if we do not have too many surgeons we certainly have enough surgeons. They are behaving in a rather socially responsible way to try to at least restrain the number of training programs.

Mr. **Waxman**. Is there an adverse economic impact on them that is causing the American College of Surgeons to have a socially responsible evaluation?

Dr. **Banta**. I think Dr. Hadley addressed that in broad terms. I will pass it back to him to be more specific. I can only be anecdotal and say that a number of surgeons in private practice have reported to me, commented at professional society meetings, and so forth that there is a difficulty in maintaining a full practice.

Some studies do show the average general surgeon is operating about half as many hours a week as the surgical societies consider to be optimal. Surgeons are not finding enough business at the moment.

Dr. **Hadley**. I would reinforce that. I think the problem is twofold. One is it is taking increasingly longer to establish a full practice for new physicians coming into a specialty area and second, keeping the appointment book filled has become increasingly difficult. I think those are the things that will very gradually affect choices of future physicians.

Mr. **Waxman**. What impact do you think high costs of the medical education has on the level of fees charged later as a practicing physician?

Dr. **Hadley**. In the short run only a very small proportion of all physicians bear the high costs of education. I suspect that fees are probably still largely determined by the existing stock of physicians already in practice who have already paid for their educations and to whom the current high cost of education are not an issue.

Over time I suspect there is a strong incentive to keep fees as high as possible and to take every opportunity possible to increase fees in order to try to amortize whatever educational debt there may be.

The ability to do that may be very much a function of local market forces in whatever area a physician decides to practice.

Dr. **Banta**. Given the fee situation that we have already talked about, with higher fees in urban areas and lower fees in rural areas, there may be an incentive because of the cost of medical education to settle in the urban area where there may not be a need for physicians.

Mr. **Waxman**. Do you feel that the high cost of medical education has more of an impact on distribution than it does on the actual fees charged?

Dr. **Hadley**. It would have an impact on distribution if there are no other compensatory measures. One option is to use programs like loan forgiveness or scholarships to offset the high cost of education in return for making certain kinds of locational or specialty decisions.

Mr. **Waxman**. Dr. Hadley, is it correct that you don't believe that the actual level of fees is so clearly related as the distribution is to the high costs of education?

Dr. **Hadley**. Let me just report what I believe to be a fact: Younger physicians tend to charge much higher fees than older physicians. Whether that reflects their higher cost of education or their coming into an area and observing what the going rate is, however high that may be, and just adopting that rate, I cannot tell.

I think it makes sense over time that fees would reflect educational costs as long as there are no constraints in the local market on the ability to raise fees.

Mr. **Waxman**. Have you done any work to evaluate the impact of medical malpractice insurance on the level of fees?

Dr. **Hadley**. No, sir. I have not.

Mr. **Waxman**. Let me thank you both. Your testimony has been very helpful. I want to commend you on your statements. Thank you for being with us.

That concludes the business before the subcommittee and the hearings on the health manpower legislation. The meeting is adjourned.

[The following statements and letters were received for the record:]

American Academy of Pediatrics

Mr. Chairman, this testimony is submitted for inclusion in the hearing record on renewal of P.L. 94-484. The policies and concepts contained herein are those of the American Academy of Pediatrics, an international medical association and children's advocate whose more than 22,000 members are dedicated to the well-being of infants, children and adolescents. The comments are derived in part from "The Future of Pediatric Education," August 1978, a report prepared by the Task Force on Pediatric Education, an organization comprised of 10 pediatric societies concerned with the health and welfare of children (see Appendix 1). Several of those organizations have conferred with the Academy on specific points raised in H.R. 6800 and H.R. 6802 as well. Thus, we believe you will find the Academy's views representative of virtually the entire pediatric community and indicative of the time and effort which we have devoted to the issue of pediatric education and manpower during the past several years.

To set the stage for our comments, allow us to attempt to define what has come to be known as the "new pediatrics." As the pediatric task force which we mentioned earlier conducted its investigations, it became clear that advances in prevention and control of traditional acute and infectious diseases were permitting the pediatrician to devote more time and attention to what had been relatively neglected areas--chronic disease; the increasing number of behavioral problems of childhood and adolescence; and what we call biosocial problems--those health problems socially induced or complicated by social and environmental factors. Because coping with the challenges of modern society will cause an increase in the incidence of biosocial problems, modern pediatric training must be directed more specifically to the treatment of those problems.

The content of experience in biosocial pediatrics should include normal and abnormal growth and development, basic behavioral science information, reactions of children of various ages to illness, education for healthy lifestyles and familiarity with the principal literature regarding child development. Residents should also learn about the nature of psychologic and achievement tests, the principal psychologic therapies, the principles of psychopharmacology, and the techniques of family counseling. They should be familiar with the developmental characteristics of the parent-child interaction, child care practices and dysfunctions in parenting.

Residents should learn to manage such family crises as death and bereavement, suicide attempts, sexual assault, accidents, child abuse, birth of a defective child, separation, divorce, abortion, and a wide range of common behavioral disorders. Furthermore, they should be able to work with the family to resolve problems in parenting, well child care, adoption/foster care, school adjustment, and learning. They should be familiar with the role of the pediatrician in the management of disease states in which psychological elements play an etiologic or contributory role.

There has been also a dramatic increase in our recognition of child health problems associated with poverty, a deterioriating physical environment, changing family structures and other social and psychological factors. There is growing evidence that encouragement of health promotion and changes in lifestyles may become more important than medical intervention in affecting morbidity and mortality. The pediatric community recognizes that pediatric education must respond to these changes in child health needs. We ask Congress to follow suit by authorizing the funds to allow us to develop and maintain an educational program relevant to those needs.

Pediatric programs have, in fact, begun to evidence a shift in emphasis toward treatment of biosocial disorders through a strengthening of ambulatory training. But the shift has been slight, and the bulk of pediatric training still takes place in hospital settings even though the burden of care for children with such problems remains largely in the community. We simply cannot continue to all but ignore the relationship between biosocial and developmental disorders such as early family adjustment difficulties and school failure and the adverse health effects of those problems. A recognition of that relationship mandates pediatric education which emphasizes the processes of human growth and development and their relationship to health and disease.

Because pediatrics is a primary care discipline, and because most pediatric problems are best handled on an outpatient basis, pediatric education should utilize the skills and demonstrate the commitment to personal, continuous care practiced by the general pediatrician. The current preponderance of hospital-based teaching in the pediatric curriculum is one indication of the dissonance between current pediatric education and the health needs of children. By the completion of formal postgraduate training, most pediatricians are extraordinarily skilled at diagnosing and managing illness, especially that of hospitalized children. As a consequence of concentrating pediatric resident education on illness, many if not most pediatric residents have only a rudimentary knowledge of the concept of normality and particularly of the variability surrounding the "average" with regard to child development and health status.

In the future, pediatricians will be called upon more and more to manage children with emotional disturbances, learning disabilities, chronic illnesses and other problems of a developmental, psychological and social nature. They will provide increased amounts of health care to adolescents. They will be expected to manage their practices efficiently, collaborate with other members of the health care team and use community resources to enhance the effectiveness of services to children and their families.

The ambulatory experience resonds to these needs by developing skills in counseling, anticipatory guidance, developmental appraisal, referral, consultation, use of screening procedures and practice management. Skills relating to the care of children with chronic illnesses and handicapping conditions are particularly importnat. Finally, the ability to coordinate services, plan comprehensive care and mobilize available community resources is essential to provide ambulatory care of high quality. To accomplish all this, there remains a distinct need for faculty development and greater support for research related to ambulatory care. Full-time faculty members in ambulatory pediatrics need formal training in the discipline; it is no longer acceptable to assume that any pediatrician can teach ambulatory pediatrics.

Unfortunately, the pediatric community finds itself in the unenviable position of responding to a dramatic shift in educational need in an atmosphere of fiscal restraint. Moreover, increasingly larger percentages of medical school funds are being devoted to the delivery of patient care, a development which we recognize is a justified response to the public demand for quality health but one which means that other sources of support are necessary if service programs in educational centers are to improve the teaching environment--particularly through the development of model ambulatory care programs. An appropriate program of grants for general pediatric training could respond to this need by earmarking funds for the development of ambulatory pediatric models. We would reiterate, also, that the Academy does not seek additional pediatric residency positions but, rather, the means to improve the quality of existing residency training and provide the necessary redirection of content.

The relative availability of funds for research and training in the sixties promoted the growth of subspecialization. The influence of these subspecialities and of the service funds associated with them was an important factor in bringing about emphasis on residency training in inpatient settings at the expense of training in ambulatory care. Traditionally, departments of surgery and medicine, as compared to departments of pediatrics, have received disproportionate levels of hospital and medical school support because of the revenue generated from their hospitalized patients. Lower rates of hospitalization and greater volume of ambulatory care have been contributing factors to under-support of pediatric departments.

The need for federal support of ambulatory training programs derives also from the present pattern of reimbursement for pediatric services by third party payors. The funds used to support pediatric residencies are pooled from many sources including Medicaid, other patient-care revenues, state appropriations and grants. Current reimbursement formulas directly and indirectly detract from the importance of ambulatory care and diminish pediatric department operating budgets by imposing restrictions on full reimbursement for ambulatory care. Medicaid reimburses well below the actual cost of providing ambulatory care in a teaching setting, and many private insurance policies do not cover ambulatory care. Sixty-five per cent of families have no insurance covering office visits to a physician. Furthermore, procedure-dominated reimbursement systems tend to discriminate against the provision of preventive services, which constitute a large proportion of good pediatric practice. Simply stated, pediatric residency programs cannot further expand into ambulatory teaching without independent support. Only separate and dedicated federal funding can accomplish this teaching and training objective.

We believe increased financial support channeled into faculty salaries to be the most effective use of increased funding. Current circumstances find medical school faculty commonly forced to "earn their keep" by delivering medical care during non-teaching hours. This obviously detracts from teaching time and effectiveness. In the pediatric field, this problem is compounded by the generally longer hours required of practicing pediatricians and the above-mentioned disproportionate financial stress on pediatric departments. A more substantial federal support program would free pediatricians on medical school faculties to do their job, namely, to teach pediatrics to the best of their ability.

As the emphasis on teaching ambulatory care increases, pediatric departments will need to cope with the serious shortages of faculty to teach in such areas as adolescent medicine, learning disabilities, care of the chronically ill, ambulatory care, community pediatrics and the behavioral sciences. Faculty development in these areas will require financial support for fellowship and research positions in these disciplines. This means that pediatric education, which is already costly, will grow even more so if it responds to the obvious health needs of our nation's children. In the past we have been much slower to finance ambulatory and preventive care than catastrophic or tertiary care. However, it is increasingly clear that economical and effective health care depends much more on the former than the latter. We ask you to recognize this situation in this and future health manpower funding proposals.

Finally, the American Academy of Pediatrics would like to offer its services to aid in implementing some of the suggestions made above.

STATEMENT BY
THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

The American College of Obstetricians and Gynecologists is a professional organization representing over 20,000 physicians providing reproductive health services and health care to women. As such, the ACOG recognizes the need for and assumes responsibility for collecting and maintaining current data with regard to obstetrics and gynecology including studies identifying practice patterns of physicians in the specialty and practice preference of medical students and residents in obstetrics and gynecology.

In part supported by the Department of Health and Human Services (under Grant #MC-R-170397) the ACOG initiated a two year project in 1977 entitled, Manpower Planning in Obstetrics and Gynecology. Grant funding has been extended an additional 2 years which will provide extensive information on the future supply and practice responsibilities of physicians and allied health professionals specializing in women's health.

As you are aware, the Graduate Medical Education National Advisory Committee (GMENAC) has been working for some time to project supply needs in 1990 for physicians across all specialties. ACOG has participated in the GMENAC effort and has contributed input in attempts to assure that the report of this Committee to Congress reflects an accurate representation of the practice of obstetrics and gynecology. Our work over the past several years compiles and documents information which we believe will be helpful to Congress as it begins its review of the Health Professionals Education Assistance Act. We gladly offer the benefit of our research, our cooperation, and any assistance from the ACOG that the Subcommittee on Health and The Environment may find helpful.

DURING THE YEARS 1974 TO 1976 WHEN THE HPEAA WAS LAST DISCUSSED IN CONGRESS, THE HOUSE CONCLUDED ITS DEBATE HOLDING THAT THE FEDERAL GOVERNMENT SHOULD CONTINUE TO PLAY A ROLE IN ASSISTING INSTITUTIONS TO TRAIN STUDENTS GOING INTO THE HEALTH PROFESSIONS. WISELY, CONGRESS REASONED THAT FUNDING SUPPORT TO INSTITUTIONS PROVIDING MEDICAL EDUCATION SHOULD MOVE AWAY FROM INCREASING THE AGGREGATE NUMBER OF PHYSICIANS AND TOWARD ACHIEVING NATIONAL OBJECTIVES IDENTIFIED AS IMPROVED DISTRIBUTION OF PHYSICIANS BY SPECIALTY AND GEOGRAPHY. LEGISLATION IN CONGRESS PROPOSED TO LINK CAPITATION SUPPORT AND INSTITUTIONAL SUPPORT TO PROGRAMS WHICH ENCOURAGED PHYSICIAN TRAINING AND SERVICE IN UNDERSERVED AREAS. THE HOUSE AND SENATE CONCURRED THAT THESE PRIORITIES WERE ESSENTIAL TO ANY FEDERAL POLICY DEVELOPED WITH REGARD TO HEALTH MANPOWER.

SUBSTANTIAL DEBATE AND DISCUSSION SURROUNDED AGREEMENT IN IDENTIFYING THE SPECIALTIES WHICH WOULD BE RECOGNIZED BY GOVERNMENT AS PRIMARY CARE SPECIALTIES. ON THIS POINT, THE HOUSE OF REPRESENTATIVES AND SENATE HELD DIFFERENT POSITIONS. THE HOUSE OF REPRESENTATIVES CLEARLY DETERMINED THAT OBSTETRICS AND GYNECOLOGY WOULD BE AMONG THOSE SPECIALTIES CLASSIFIED AS PRIMARY CARE. IN ITS COMMITTEE REPORT TO ACCOMPANY HR. 5546 (REPT. NO. 94-266), MEMBERS OF THE HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE PROPOSED THAT THERE BE ESTABLISHED "A LIMITATION ON THE NUMBER OF MEDICAL RESIDENCY POSITIONS IN THE UNITED STATES .... INCLUDED IN THAT PROVISION IS A REQUIREMENT THAT, IN DESIGNATING MEDICAL RESIDENCY PROGRAMS THAT MAY BE AVAILABLE IN THE UNITED STATES, PARTICULAR ATTENTION SHOULD BE OFFERED TO THE NEED FOR MEDICAL RESIDENCY TRAINING IN PRIMARY CARE SPECIALTIES OF GENERAL INTERNAL MEDICINE, GENERAL PEDIATRICS, FAMILY MEDICINE, AND OBSTETRICS AND GYNECOLOGY." (PAGE 43)

As this legislation moved toward enactment, the provision taken by the House acknowledging and supporting obstetrics and gynecology as a primary care specialty was lost in Conference. As implemented, P.L. 94-484 excludes obstetrics and gynecology residencies from support as training primary care physicians.

The American College of Obstetricians and Gynecologists would like to take this opportunity to illustrate several points which we feel counter present policy and which we feel provide a significant argument in favor of recognition of obstetrics and gynecology as a primary care specialty in the HPEAA reauthorization legislation. We ask the Subcommittee to reconsider this issue in light of the following and to retain and sustain the House's position to include obstetric/gynecologic residencies with other primary care residencies during the reauthorization process.

Support for this position is reflected in the following:

.... Health Manpower Reserach funded by DHHS and conducted by Mendenhall at the University of Southern California examined practice patterns across all specialties. Applying the same definitions to all specialties, Mendenhall found that 78% of patient encounters with obstetrician/gynecologists can be classified as of a primary care nature. Contrast this finding with Mendenhall's report on general internal medicine where 73% of patinet encounters were found to be of a primary care nature. Additionally, Mendenhall found that every day in the United States general internists see 293,000 women; obstetricians and gynecologists see 309,000 women.

.... Agreement has been reached on this issue within the private

SECTOR WHICH CLASSIFIES OBSTETRICS AND GYNECOLOGY ALONG WITH PEDIATRICS, GENERAL INTERNAL MEDICINE, AND FAMILY PRACTICE AS A PRIMARY CARE SPECIALTY. THE COORDINATING COUNCIL ON MEDICAL EDUCATION, A PARENT ORGANIZATION WHOSE MEMBERS INCLUDE THE AMERICAN MEDICAL ASSOCIATION, THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES, THE AMERICAN HOSPITAL ASSOCIATION, THE AMERICAN BOARD OF MEDICAL SPECIALTIES, AND THE COUNCIL OF MEDICAL SPECIALTY SOCIETIES, RECOGNIZES THIS DESIGNATION.

.... EVEN THOUGH RESIDENCY PROGRAMS IN OBSTETRICS AND GYNECOLOGY ARE OMITTED FROM THE HPEAA'S PRIMARY CARE DEFINITION AND THEREFORE DO NOT RECEIVE PRIORITY FUNDING, RESIDENCY PROGRAMS IN OBSTETRICS/GYNECOLOGY ARE INCLUDED UNDER THAT ACT ALONG WITH THE RECOGNIZED PRIMARY CARE SPECIALTIES AND ARE REQUIRED TO PROVIDE THE SAME SHARED RESIDENCY OPPORTUNITIES. THE BUREAU OF HEALTH MANPOWER, DHHS, INCLUDES OBSTETRICS/GYNECOLOGY AS WELL AS RECOGNIZED PRIMARY CARE SPECIALTIES FOR PURPOSES OF IDENTIFYING HEALTH MANPOWER SHORTAGE AREAS. IN LINE WITH THIS POLICY, THE NATIONAL HEALTH SERVICE CORP ACTIVELY SEEKS AND RECRUITS MEDICAL STUDENTS WHO HAVE DEMONSTRATED INTEREST IN PURSUING A RESIDENCY IN OBSTETRICS AND GYNECOLOGY AND WHO WOULD EVENTUALLY FULFILL THEIR SERVICE OBLIGATION IN HEALTH MANPOWER SHORTAGE AREAS.

WE FEEL THAT DHHS POLICY AND IMPLEMENTATION OF THAT POLICY HAS CLEARLY DEMONSTRATED A PRIORITY NEED FOR TRAINING OBSTETRICIANS/GYNECOLOGISTS. WITH THIS IN MIND, PRESENT HPEAA AUTHORITY WHICH OMITS OBSTETRICS AND GYNECOLOGY RESIDENCIES FROM SPECIAL TRAINING FUNDS IS IN CONFLICT WITH THE NEED IDENTIFIED BY DHHS. ADDITIONALLY, WE FEEL THAT RESEARCH HAS DEMONSTRATED THE HIGH DEGREE OF PRIMARY CARE WHICH IS ACTUALLY PROVIDED BY THE OBSTETRICIAN AND GYNECOLOGIST IN PRACTICE.

AGAIN, WE REQUEST THAT THE SUBCOMMITTEE CONSIDER THE MERITS OF THE RESEARCH AND THE PERSUASIVENESS OF INFORMATION WHICH HAS BECOME AVAILABLE SINCE ENACTMENT OF P.L. 94-484. BY SO DOING, WE ARE HOPEFUL THAT THE POLICY CONTAINED WITHIN THE ACT WITH RESPECT TO OBSTETRICS/GYNECOLOGY RESIDENCIES CAN BE REVISED DURING THE REAUTHORIZATION PROCESS.

Statement of the American College of Physicians

on Health Manpower Legislation

The American College of Physicians (ACP) is a 49,000-member organization representing a broad spectrum of practitioners of internal medicine, medical educators, clinical investigators and residents and fellows in internal medicine training programs. The College supports the development and implementation of a national health manpower policy predicated on a foundation consisting of detailed analysis of past experience and estimates of future needs. As personal physicians responsible for a large portion of the comprehensive medical care of adults in this country and as educators involved in the training of future physicians, we are particularly concerned with the creation of successor legislation to the expiring Health Professions Educational Assistance Act of 1976 (P.L. 94-484).

The existing comprehensive legislation provides authorizations for numerous federal programs which affect not only the entire spectrum of undergraduate and graduate level health professions education, but also the delivery and availability of health care throughout the country. The Act encompasses programs affecting the construction of health professions schools, student financial assistance, funding for special training programs, the designation of health manpower shortage areas, the National Health Service Corps, assistance for health services research and technology, immigration of foreign medical school graduates, the provision of health care services in underserved areas, and many other programs and special projects.

Each of these diverse programs impinges upon the others; no single program can be adequately evaluated in isolation without considering its overall ramifications. Any renewal legislation will significantly influence the future practice of medicine and the delivery of health care in this country for a period far beyond the actual life of the legislation. The American College of Physicians, therefore, urges a thorough evaluation of existing programs and careful examination of new legislative proposals before enactment of any renewal legislation.

A final report representing the culmination of a four-year effort by the Graduate Medical Education National Advisory Committee (GMENAC) is expected later this year. This report will attempt to project the nation's future health manpower needs, provide evaluations of existing health manpower programs and identify alternative approaches to improve the geographic and specialty distribution of health care professionals. We do not know at this time whether we will endorse the findings or methodology of GMENAC. Time will be needed to understand and evaluate their methodology, to validate their findings and to digest and respond to their recommendations. However, we believe it is important that the findings and recommendations of GMENAC be carefully reviewed and considered in any deliberations concerning national health manpower policy. We do not believe that adequate data are now available upon which definitive conclusions can be drawn.

Medical School Enrollment

The best data currently available, in our judgment, suggest that the overall supply of physicians may exceed the projected need by 1990 and thereby produce a physician surplus. GMENAC estimates that the supply of active practicing physicians will have increased to nearly 600,000 by 1990, an increase of 58% above 1975. Due to the momentum of the health system, most of these physicians will remain in practice for a considerable period of time after 1990. This growth in physician supply will outpace the projected population growth, so that by 1990 there will be 245 physicians for every 100,000 people in the United States. In 1975, the physician-to-population ratio was 177 per 100,000; in 1980 the ratio is estimated to be 197 per 100,000.

In the late 1950's, the Bane Commission issued its report on medical education in the United States; there were 141 physicians per 100,000 population.[1] Recognizing the difficulties in determining the "ideal" number of physicians, the Bane Commission concluded that, since the current (1959) state of the health of the nation appeared to be generally acceptable, maintenance of the ratio of 141 per 100,000 was assumed to be a reasonable national goal.

To assure that this ratio would be sustained, as the nation's population was expected to grow to a projected level of 235 million people by 1975, the Bane Commission recommended a major expansion program for medical education. This was designed to increase the annual medical school output from 7,500 in 1959 to 11,000 by 1975. The numbers of students in existing schools were to be expanded, and 20 new medical schools were proposed. Stimulated by the infusion of federal money from the subsequent Health Professions Educational Assistance Acts of 1963, 1968, 1971 and 1976 plus considerable stimulus from individual state legislatures, medical and other health professions training programs burgeoned. Instead of 20 new medical schools, over 40 have been built. Instead of 11,000 graduates in 1975, there were 12,714. This year, approximately 16,000 new graduates have been projected and the number will continue to expand based on commitments already made. The unanticipated influx of foreign medical graduates (FMGs) to this country, coupled with a decline in the population growth rate, further accounted for the increase in the physician-to-population ratio.

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[1] Physicians for a Growing America -- Report of the Surgeon General's Consultant Group on Medical Education (Frank Bane, Chairman), PHS Publication 709, Washington, USGPO, 1959.

Should the supply of physicians exceed need and produce a surplus, serious consequences may ensue for the American public, the educational community, and the medical profession. There is a significant body of opinion that believes that the aggregate costs of physician activity - clinical examinations, laboratory and other diagnostic tests, prescribed drugs and other therapeutic interventions - could escalate beyond what is needed to ensure optimal health care for the population. Such an expenditure could have a significant adverse impact on the national economy.

Recognizing that the number of physicians is increasing faster than the size of the population, the American College of Physicians recommends that further expansion of current medical school enrollment be stopped.

The possibility of a surplus of physicians should be seriously considered by public policymakers and the academic community. Legislation replacing the Health Professions Educational Assistance Act of 1976 must be sensitive to the current situation regarding health manpower and current projections of a future overall excess of medical personnel. It is also important for all health manpower projections to differentiate clinical investigators and medical educators from full-time medical practitioners. Any such legislation should be sensitive to variations in availability among different types of health care practitioners. The full effects of any legislative actions designed to influence medical education would not be realized until 1990 or beyond, due not only to the long educational and training periods involved but also due to the extensive time required for educational institutions to plan and implement changes in educational programs.

We submit the following additional remarks in the hopes of being of some assistance to the current health manpower deliberations.

Geographic Distribution

1. The College recognizes that the problems of physician supply are affected by the geographic distribution of practitioners. The effectiveness of the National Health Service Corps (NHSC) in correcting geographic distribution problems should be reexamined in relation to recruitment, placement of assigned physicians and the development of suitably prepared practice sites in underserved areas. The NHSC is a viable pathway for attracting physicians to shortage areas, but it should not be the only pathway. Alternative sources of financial aid outside the NHSC should also be available.

2. Area Health Education Centers (AHECs) and other remote-site education and training programs have proven to be of assistance in correcting geographic maldistribution of physicians. These programs should be supported with due recognition of local and regional needs.

3. The use of financial incentives and other inducements should be further explored by federal policymakers in an effort to encourage the availability of physician services in currently underserved areas. Ample provision for opportunities for professional contacts with colleagues and for continuing medical education activities are important in constructing viable professional arrangements. Adequate and accessible hospital facilities are also factors which may influence physician distribution. Fiscal arrangements alone are unlikely to resolve problems of access to medical care in underserved areas in the absence of measures to address the professional needs of physicians.

Specialty Distribution

1. The College emphasizes both the role of the internist in providing high quality primary care services and the role of the subspecialist in internal medicine in providing significant amounts of similar primary care services. Federal and state financial incentive programs should be expanded to encourage medical schools and teaching hospitals to provide educational programs in primary care fields; this should include internal medicine, pediatrics and family practice.

2. Program directors and institutions responsible for graduate medical educational programs should consider national manpower needs as well as local and regional requirements. This should be a voluntary effort by the medical profession and should consider the issues of need, supply and distribution of physicians and the relation of these items to training programs. The College re-emphasizes the need for an accurate data-base for projected health manpower requirements in order to implement such a program.

3. The College supports the current accreditation efforts of graduate medical educational programs through the Liaison Committee on Graduate Medical Education and its Residency Review Committees in maintaining the educational standards for specialty and subspecialty training.

Medical Education

1. Appropriate and adequate student financial aid programs must be supported at the federal and state levels in order to allow qualified students to enroll in medical school. Financial assistance should be sufficient to allow qualified medical

students to complete their academic and residency training. Repayment provision should be sufficiently lenient so that new physicians are not deterred for financial reasons from engaging in the practice of primary medical care or from establishing practices in medically underserved areas.

2. The College advocates continued federal support for educational programs that assist disadvantaged students.

3. The College urges that funding to medical educational institutions be continued with the following components:

   a. Basic general institutional support to assure maintenance of high educational standards.

   b. Special initiatives to meet specific needs such as geriatric instruction, primary care instruction, nutritional education and basic or clinical research.

Specific Federal Intiatives Due to Expire in 1980:

1. The College supports extension of the following:

   a. Authority to provide assistance to health professions schools which serve predominantly minority students and are in financial distress.

   b. Authority for scholarships for students with exceptional financial needs in their first year of study and grants for recruiting students from disadvantaged backgrounds;

   c. Federal subsidies for Health Education Assistant Loans (HEAL);

   d. Authority for construction of ambulatory primary care teaching facilities.

2. The College supports the following new proposals:

   a. Extension of the repayment period from 10 to 15 years for Health Professions Student Loans (HPSL) and provision to allow each educational institution authority to set criteria for HPSL loan eligibility.

   b. New authorizations for grants and contracts to help professional schools offer training in geriatrics.

   c. Expanded state and federal assistance to support teaching programs that encourage careers in teaching and research.

3. The College sees a continued need for authorization to support training of primary care physicians in internal medicine, pediatrics and family practice.

4. The College notes that physical plants of many medical schools will become outmoded and require new construction over the next few years. Special funding for replacement or remodeling of old buildings and other unusual circumstances should be available on an ad hoc basis in response to need.

Foreign Medical Graduates

1. In light of current projections of physician supply, the College supports the policy of restricting further permanent immigration of foreign medical graduates.

2. The College, recognizing this country's obligation to share its medical knowledge, believes that foreign physicians should not be denied opportunities in this country to obtain the extent of medical training which is in the best interests of the trainee's home country. When requested by a trainee's home government, time in this country sufficient to qualify for American Specialty board certification would seem appropriate.

3. Accordingly, the College supports legislative efforts to amend Section 212 (J) of the Immigration and Nationality Act by substituting a more flexible system for determining the duration of visa status for each FMG on a case-by-case basis. Justification of exceptions should be authorized by the applicant's home country.

4. Preferred status for physicians applying for permanent immigration visas should be available only in the exceptional cases of individuals with unique qualifications who will fill a national need for research or teaching.

Manpower Data Needs

1. The College supports efforts to obtain accurate health manpower data for planning through an effective continous system of data collection.

We recognize that there are many aspects of health manpower policy, and it is difficult for any one organization's statement to embrace them all. The American College of Physicians stands ready to submit further testimony or to otherwise share the expertise of our membership.

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PHYSICIAN MANPOWER

A STATEMENT BY
THE AMERICAN COLLEGE OF SURGEONS
AND
THE AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS

The American College of Surgeons and the American Association of Neurological Surgeons have repeatedly enunciated the principle that the best care is provided when fully educated and experienced practitioners are given practice privileges for which such preparation and qualifications prepare them.

Consistent with this principle is the firm conviction of both ACS and AANS that an adequate number of surgeons must be educated if the nation's need for surgical care of high quality is to be met. The importance of surgical residency training programs cannot be overstated. Besides assuring the education of qualified surgeons, surgical residency programs provide resources for the advancement of medical knowledge and standards of surgery; society benefits from wide application of these advances in surgical care. An adequate supply of surgeons for teaching and research is also necessary to assure the quality of these training programs.

Determining an adequate number and an appropriate distribution of physicians is today a matter of major concern to both the public and the private sector. A shortage of physicians or a maldistribution by specialty could seriously deprive patients of ready access to the health-care system and lower the quality of care.

Measuring Physician Adequacy

Physician-to-population ratios are commonly used to measure whether the supply of physicians is adequate to meet patients' demand for care. Such ratios are an overly simplistic measure because they fail to take account of the many variables affecting the availability of physicians' services. Planning for physician manpower requires the evaluation of many more factors than physician-to-population ratios. Some of the major factors are the productivity of physicians and their patterns of referral; practice organization; the supply, function, and employment of nurses and allied health personnel; patient accessibility to services and facilities, and the characteristics of a region's population. Moreover, the adequacy of the supply of physicians cannot be determined without considering the quality of services provided. Many recommendations for the appropriate number of practitioners have ignored the level of training or the qualifications of the practitioners providing care.

More sophisticated approaches to manpower planning have sought to evaluate patient need for physician services. The terms "need" and "demand" are often used interchangeably, but a clear distinction is necessary in discussions of medical care.

"Need" may be defined as the type and range of medical services that a population ought to consume to maintain an acceptable level of health. Yet when need has not been quantified with any degree of accuracy, reliance on such a basis for manpower planning is improper because it ignores the propensity of patients to seek services or their ability to purchase them. Basing estimates of physician manpower on need seems a futile exercise, especially when one considers that need for care is potentially insatiable.

"Demand" may be defined as the quantity or volume of service actually consumed. Many variables influence patients' demand for care. Individual characteristics, such as lifestyle or occupation, influence health levels. Socioeconomic or cultural background may influence a patient's propensity to seek care. Aggregate demand for care is influenced by changing demographic and financial factors, such as an aging population and increasing insurance coverage. New technologies, both diagnostic and surgical, may increase demand for care, since they make possible the treatment of many conditions previously undetected and inoperable. As the American public becomes more knowledgeable about matters of health, its expectations for medical care are raised, and demand for services, especially for care by specialists, may increase.

Supply and Distribution of Specialists

Recently, the emphasis on the total supply of physicians has decreased and the emphasis on the supply of various specialists has increased. A widely accepted notion has evolved that there is a shortage of primary-care physicians and a surplus of specialists. This perceived shortage of primary-care physicians suffers from a lack of documentation and imprecise or inappropriate definitions.

The literature provides no firm basis for the contention that a shortage of primary-care physicians exists; the belief that increasing the number of primary-care physician will allow the public to have "access on demand" to a physician remains undocumented. Definitions of "primary care" are imprecise. Some suggest that the term relates to the level of complexity in treatment or to the stage of the presumed illness when the patient first sees a physician. Others suggest primary care as a label for the services provided by the specialties of general internal medicine, family practice, and general pediatrics, or according to some, obstetrics-gynecology.

The discussion about supply and distribution of specialists is hampered by the lack of data and the unreliability of methods to determine the optimal range and volume of services provided by a physician in any specialty. Relying solely on specialty designation is fallacious. The kinds of services provided by a physician may depend as much on the medical needs of a community or the individual patient as on the physician's specialty label. When specialists are obviously providing what is imprecisely defined as primary care, simple ratios of specialists to generalists cannot be used in manpower planning, particularly when the generalists also provide a certain amount of secondary or tertiary care.

The ultimate "proof" of the shortage of primary-care physicians is assumed to lie in the failure of the nation to meet arbitrarily determined ratios of primary-care physicians to population. Yet criteria for determining shortages may be changed at any time to justify actions aimed at increasing the supply of primary-care physicians. Recent regulations for designation of health-manpower shortages areas arbitrarily modified the suggested ratio of primary-care physicians to population from 1 per 4,000 to 1 per 3,500. Health-planning goals proposed by HEW would modify this ratio to 1 primary-care physician equivalent per 2,000 population. Criteria for determining shortage areas were also modified to exclude the contribution by specialists to primary care, such as by general surgeons practicing in rural areas.

Improper geographic distribution has been cited as a reason to increase the number of certain types of physicians in the United States. However, recent studies indicate that surgical specialists are quite well distributed throughout the country, even in counties of under 10,000 population.

Residency Programs

Residency training programs have become the focus of attempts by government to adjust the distribution of physicians by specialty and location. The physician manpower training act passed in 1976 specified that to be eligible for capitation grants, medical schools must meet certain percentage requirements for first-year residency positions in primary care specialties. This law and previous legislation, together with voluntary changes in physician specialty selection, have increased the proportion of first-year residents in primary-care specialties to more than fifty percent of the filled first-year residency positions. A similar trend is evident in board-certification of specialists: the number of certificates issued in the primary-care specialties has in recent years exceeded fifty percent of all certificates.

In addition to the shift in specialty choice by residents, other trends in physician training are influencing the supply of specialists. Manpower legislation has also reduced the supply of foreign medical graduates (FMGs) entering the country; those who do enter for residency training are prevented from completing training in most specialties because of restrictions on the duration of their stay. Women now comprise over 20 percent of medical school graduates. Because women have had a greater tendency to enter primary-care specialties in the past their increasing numbers may influence the specialty distribution of physicians.

Because the supply of domestic medical graduates is leveling off, and the number of FMG residents has been reduced, any increase in primary-care training positions must subtract from the number of those positions available for all other specialties. This raises the serious risk of not producing enough specialists to meet patients' demand for specialty care of high quality. The probability of a specialty imbalance is heightened by the possibility that changes mandated by government will be added to changes already occurring voluntarily in the private sector.

Conclusions

Recognizing the complexity of the issues involved in manpower planning, the American College of Surgeons and the American Association of Neurological Surgeons wish to emphasize the following:

1) The interests of the public are best served by assuring an adequate number of both generalists and specialists to meet patients' demand for high-quality medical care. Efforts to determine an adequate number and appropriate distribution of physicians must consider all variables in patients' demand for medical services and in the way that physicians practice. Simplistic physician-to-population ratios are not an acceptable measure of adequacy of physician supply.

2) Because of the long training period for physicians, the effects of changes in residency training on the supply of practicing physicians do not become evident for several years. The long-term effects of previous legislation and of voluntary changes in preferences for medical specialties should be evaluated before the current system is modified.

3) The concept of "primary care" should be either clearly defined or dropped as a manpower designation. The arbitrary classification of certain specialties as "primary care" does not consider the nature of the care provided by both generalists and specialists.

4) The phenomenon of "leakage" from such primary care specialties as general internal medicine into more specialized fields has been used to justify an increase in the proportion of primary care residency positions. It would be more rational to stop the leakage rather than to produce more generalists at the expense of reducing the supply of specialists.

5) Some foreign-trained physicians should be allowed to remain in the United States as long as necessary to complete residency training in the specialty of their choice.

6) Efforts to improve the availability of medical care to underserved areas should include improved arrangements for referring and transporting patients to currently available resources for medical care.

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THE AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

The American Association of Nurse Anesthetists ("AANA") is a professional organization whose membership is comprised of Certified Registered Nurse Anesthetists ("CRNAs"). There are presently 15,000 active practicing CRNAs in the United States. Each one of these individuals holds unique qualifications which allow them to administer anesthesia. AANA submits that in the absence of an anesthesiologist, or a physician anesthetist with a significant background in anesthesia, that the CRNA possesses the necessary knowledge, skill and educational background to be involved in the assessment, management and administration of a patient's anesthesia requirements under the medical direction of a responsible physician. For individuals to represent themselves to the public as CRNAs, they must hold a current license as a registered professional nurse, have graduated from an accredited program of nurse anesthesia, have passed a rigid qualifying examination, and must be involved in a program of continuing education in anesthesia.

We are interested in legislation to extend the authority for the nurse anesthetist traineeship program in the Nurse Training Act Amendments of 1979, authorized for FY 1980 only at an authorization level of $2 million. HEW has requested $1 million for FY 1980 and $1 million for FY 1981 in its budget. The $1 million for FY 1980 was to be accomplished by a transfer of funds but that must be approved by the Appropriations Committee which has not acted yet on a supplemental for FY 1980, nor on the FY 1981 bill. We support H.R. 6802 and its three-year extension of the anesthetist traineeship program. We think the authorizations are reasonable and hope that we can obtain a supplemental appropriation to begin this program in FY 1980.

We would now like to address ourselves to the provisions relating to nurse anesthetist training.

1. The Educational Program and Training of a Nurse Anesthetist

As this testimony will point out, the CRNA is a much needed element within the health care system. To understand the type of educational program the CRNA must complete (and the type of program for which we are requesting Federal support), allow me to delineate the current educational requirements for CRNAs. Building on the professional nursing base, the student nurse anesthetist must complete the following program: Orientation to Anesthesia Practice - 45 contact hours; Chemistry and Physics of Anesthesia - 45 contact hours; Advanced Anatomy, Physiology and Pathophysiology - 120 contact hours; Principles of Anesthetic Management - 60 contact hours; Pharmacology of Anesthetic, Adjunctive and Ancillary Drugs - 60 contact hours; and Clinical Correlative Conferences - 35 contact hours. Also included in the clinical program is a requirement of a minimum of 600 hours of actual anesthesia time in which clinical instruction is provided in situations where students actually administer the anesthesia. Other requirements include a minimum of 450 cases of anesthesia actually administered with these cases distributed according to types of techniques required and variety of drugs used. With this type of background, there should be no doubt as to the ability of the CRNA to provide the patient with quality anesthesia care.

Training programs are graduate-level programs for registered nurses. Training involves 18 to 24 consecutive months of course work and clinical instruction and a certificate of graduation is received when the program is successfully completed. All training programs are accredited by an accreditation body approved by the Office of Education. There are presently 165 of such programs while there were 225.

2. The Dimensions of Nurse Anesthetist Practice

As previously stated, the CRNA is a vital element within the health care system in the United States. Nationwide, nurse anesthetists are providing safe, reliable and economic anesthesia care to approximately one-half of all of the patients undergoing anesthesia. Included in this statistic is the fact that in rural areas nurse anesthetists account for approximately two-thirds of all anesthesia care rendered. Throughout many areas in the country, nurse anesthetists are the only providers of anesthesia care. (In a 1971 survey of hospitals, forty percent of all of the hospitals surveyed had only nurse anesthetists on the staff.) According to figures published in the February, 1978 issue of Anesthesiology, the national mean population ratio for active practicing nurse anesthetists is 7.20 per 100,000. This figure compares with a distribution of 4.64 anesthesiologists per 100,000. A breakdown of these figures on a regional basis will show that the areas with the thinnest distribution of anesthesiologists have the highest distribution patterns for nurse anesthetists.

3. Supply and Need for Nurse Anesthetists

Not only are CRNAs a vital segment of the health care system within the United States, there is a definite projected need for more nurse anesthetists in the future. According to a 1976 study by the H.E.W. Bureau of Health Manpower on "Supply, Need and Distribution of Anesthesiologists and Nurse Anesthetists in the United States, 1972 and 1980" (HRA:77-31), there is a projected need of from 22,000 to 25,000 nurse anesthetists for 1980. Obviously, there is a serious shortage in this field which provides approximately half of all anesthesia services in the United States. Inclusion of the traineeships for students in schools of nurse anesthesia in the Nurse Training Amendments of 1979 will be the first step on the part of the Federal Government to rectify this shortage.

The fact that nurse anesthetists are a significant group in delivery of anesthesia services was pointed by by Dr. Feldstein of the University of Michigan in a study of the 16,500,000 surgical procedures performed in 1974. The largest percentage of anesthetics administered, 48.5%, was rendered by CRNAs; 38.3% was rendered by anesthesiologists, including both board-certified and non-board-certified; 9.7% by physicians other than anesthesiologists; and 3.5% by registered nurses other than CRNAs. A further breakdown of those procedures indicates that certified registered anesthetists administered approximately two-thirds of all the anesthesia procedures in hosptials smaller than 100 beds. Anesthesiologists tend to congregate in larger hospitals, over 200 beds, where they administered 47.5% of all anesthesia compared to 42.5% for Certified Registered Nurse Anesthetists.

4. Economics of Nurse Anesthetist Services

The majority of nurse anesthetists are salaried hospital staff, whose services are billed by the hospital as part of hospital operating room costs. According to the U.S. Department of Labor, Bureau of Labor Statistics,"Industry Wage

Survey of Hospitals, August, 1975 - January, 1976", the average hourly wage for nurse anesthetists working in 21 major metropolitan areas was $8.02. Based on a 40-hour work week, the average annual earnings for a nurse anesthetist would be $16,681.60. This figure compares with full-time equivalency earnings of hospital-based anesthesiologists of $80,000 as determined by a Health Care Financing Administration"Study of the Reimbursement and Practice Arrangements of Provider-Based Physicians, December, 1977" (Contract No. 600-76-0055). An analysis of these two salary figures indicates that where nurse anesthetists are providing anesthesia services, the cost to the patient should be substantially lower than where anesthesiologists are providing the services. Even where a team approach is used, the fact that some of the time utilized is of CRNAs rather than anesthesiologists would indicate efficiency and cost savings.

5. Need for Federal Training Support

Nurse anesthetists are clearly a shortage field in health care. Possibly twice as many nurse anesthetists are needed for 1980 as are practicing now according to the HEW study cited above.

One of the obstacles to obtaining them is the lack of financial support for trainees. Training programs are generally for two years; a substantial graduate program. (Stipends for research careers are, for example, $10,000 to $13,000.) The total of tuition and all costs is, at a minimum, now $6,000 to $8,000 per year to the student, with living costs for an individual very near that. Tuition costs range considerably with some at

$2,000 to $2,500 and others only nominal with the hospital assuming all costs. Hopsitals also offer stipends but the average is about $3,000. With hospitals attempting to limit costs and inflation rampant, hospitals are able to devote less to these programs than in prior years. Many hospitals have dropped their programs entirely; the number has decreased from 235 to 165 in recent years. Students are generally unable to hold part-time jobs because the nurse anesthesia program run for 18 to 24 consecutive months. In addition, rotating clinical schedules prevent part-time work in the evenings and on weekends. The financial problems mentioned above deter students from entering this field. Loans are difficult to obtain and entry level salaries are in the $15,000 range with average salaries after 5 years at $20,000. Such salary levels are not conducive to borrowing particularly if an individual has a family to support.

Traineeship support authorized at $2 million, $3 million and $4 million would assit in meeting the needs of this program. The hospital training programs are not eligible under the Higher Education Act for any student aid because they are not in nursing colleges nor diploma schools of nursing. Thus, assistance is particularly important.

To the institution, the major financial burden is in making stipends available to students. With living costs what they are and no time for part-time work, stipends are critical. Institutions put up $3,000 on the average toward these living and educational costs of $6,000 to $8,000. Limited resources prevent institutions from offering more aid or from offering aid to more students. Federal support to the institutions for traineeships will allow a greater number of students to enter programs since some programs are prevented from expending due to the lack of stipend money. It will also relieve the burden on low income students to permit their entry into the program. In addition, with the Federal Government picking up some of the traineeship costs, institutions will be able to devote some of their future funding to program expansion.

It should be noted that the number of nurse anesthetist training programs has decreased by about 60. These were the smaller programs. Federal support may prevent such harmful attrition and stimulate the development of new programs.

With respect to operating costs of nurse anesthetist training programs, patient care hospital revenues support such activity as staff, supplies and teaching space. We note with satisfaction, that such costs of hospitals are excluded from the recent hospital cost containment legislation offered by Senators Talmadge and Dole.

We appreciate the opportunity to testify and your Subcommittee's attention to this matter.

THE AMERICAN ACADEMY OF PHYSICAL MEDICINE & REHABILITATION

Mr. Chairman:

My name is Joseph Honet, and I am President of the American Academy of Physical Medicine & Rehabilitation, a professor of medicine at Wayne State University, and Chairman of the Department of Rehabilitation Medicine at Sinai Hospital of Detroit. The American Academy of Physical Medicine & Rehabilitation is a medical specialty society representing about 1300 physicians who are specialists in physical medicine and rehabilitation. It should be noted that while I represent a medical society and am here to discuss health care programs, the budget items being discussed, rehabilitation, are for the first time in a department other than Health. All rehabilitation programs were transferred to the new Department of Education in the legislation creating that Department.

Need for Physicians Trained in Physical Medicine and Rehabilitation

The shortage of physicians in the field of rehabilitation medicine is well documented. A 1972 study financed by the Commission on Rehabilitation Medicine, "Bulletin No. 14", and subsequently relied upon by the GAO, and the Bureau of Health Manpower and corroborated by the Rehabilitation Services Administration, indicated an average need for 1980 of about 4000 physicians in physical medicine and rehabilitation. Using assumptions requiring a higher but reasonable level of care, 6000 physicians were estimated as necessary. The GAO Report on Physician Distribution by specialty, May 16, 1978, uses two physician-to-population ratios: 1 to 50,000 recommended by the American Academy of Physical Medicine & Rehabilitation and 1 to 77,000 recommended by HEW. These ratios result in need for between 3000 and 4500 physicians in this specialty. This shortage problem was emphasized by this Subcommittee in its report on the FY 1978 and FY 1979 appropriation bill.

Most recently the Commission on Rehabilitation Medicine estimated a long range need for 1990 of 5000 specialists in rehabilitation medicine.

The GAO Report and a 1976 study by the Center for Health Services Research and Development indicate a supply of about 1700 specialists in rehabilitation medicine. Of those, only about two-thirds are board-certified specialists in physical medicine and rehabilitation. The Commission on Rehabilitation Medicine estimates a supply of 2300 for 1990.

"Bulletin # 14" is corroborated by the HEW study "Physician Specialty Maldistribution: 1975". This study frequently mentions physical medicine and rehabilitation as being one of the specialties that is in a shortage situation. The study recognizes that national health insurance will increase demand for physicians in this specialty even more than for physicians in primary care, for example, and that the increase in demand will be substantial if national health insurance is enacted. In general, irrespective of national health insurance, the study indicates a growing interest in rehabilitation which may significantly increase demand. See Chapter 5, page 12.

If there is a reduction in the number of foreign medical graduates trained and practicing in this country, and it appears that there will be, the shortage of specialists in physical medicine and rehabilitation will be exacerbated considerably. The specialty is highly reliant on foreign medical graduates who presently make up close to 69% of all residents.

Further information on the shortage of specialists in this field can be derived from the data of the national physician matching program for purposes of placing interns and residents. On the average, only 30% to 40% of the hospital staff positions being offered for residents or interns in rehabilitation medicine in the past 5 years have been filled. Additional traineeships for residency training in physical medicine and additional support for teaching rehabilitation medicine to undergraduates would assist in filling these positions for which there are not enough applicants now.

The reasons why this shortage in rehabilitation exists are numerous. First, the field is not a glamorous one such as surgery and it is not as remunerative compared to some other medical specialties. Second, in the present educational framework in medical schools, undergraduate students in medical schools are not exposed sufficiently to the field of rehabilitation. Rehabilitation curriculum is not given enough time in undergraduate education, unlike specialties in primary care which are given a substantial amount of time in the undergraduate curricula. Third, many medical schools do not have departments of physical medicine and rehabilitation (about 40 to 50). Many of these medical schools are not patient-oriented but are academically-oriented and, as a result, both undergraduate curricula and, in particular, residency programs reflect the research interests of the institution and of the National Institute of Health. As medical schools become more patient-oriented, it is likely that rehabilitation as well as primary care will receive more attention in the curriculum. Fourth, there are not enough physicians trained in physical emdicine and rehabilitation who can serve as supervisors and educators. Thus, it is difficult to get sufficient exposure to students and it is difficult for hospitals to establish appropriate supervisory programs for the residents which they so badly need in rehabilitation.

The American Academy of Physical Medicine & Rehabilitation believes that a ratio of about one specialist in phyiscal medicine and rehabilitation per 50,000 population represents a reasonably adequate ratio of physicians-to-population. Certainly, we do not feel that this is an ideal or optimal ratio, but it does reflect approximately the best ratio of physicians-to-population in the United States at the present time in a general situation in which there is a drastic shortage and a shortage which affects even a state such as New York with the best supplied population. The New York State ratio was 1.92 physicians per 100,000 population as of 1971. Since that time, demand has increased because funding for rehabilitation services has improved; e.g., Medicare guidelines clarifying rehabilitation coverage were issued only in 1972 and their effects are just being felt within the past few years. Second, demographic data indicates that demand in the future for rehabilitation care will be growing due to the substantially greater proportion of the population who will be aged, for example. Expected broadending of coverage for rehabilitation and Workmen's Compensation law, existing broadening of coverage in state no-fault auto insurance laws, and the expected enactment of some form of national health insurance including catastrophic coverage is likely to increase demands substantially beyond where it is now, not to speak of where it was in 1971. Thus, choosing the ratio of New York State which had the best ratio of physicians-to-population in 1971 seems to be a reasonable figure to pick as a ratio for current adequacy. It should be noted that the 1-to-50,000 ratio is underestimated because this is based upon the current predominant method of hospital care practice. Therefore, it does not consider needs which exist in private practice, in supportive nursing home programs and other community involvement by physiatrists.

As indicated above, the American Academy of Physical Medicine & Rehabilitation believes that the enactment of national health insurance will stimulate a substantial increase in the demand for medical rehabilitation services. This fact is borne out by the HEW study referred to above. It assumed that any form of national health insurance will include catastrophic coverage and that medical rehabilitation will be a covered service. Medical rehabilitation is presently a covered service under Medicare but there are substantial limits in the number of days of care covered. The limits in Medicare result from limits on stay which catastrophic coverage would hopefully correct.

I would also like to direct your attention to a policy paper published by the White House on "National Health Care Policies for the Handicapped" which focuses on the shortage of personnel in the rehabilitation field. That paper makes the point that about 20 million people potentially need medical rehabilitation services. That paper recommends increased training funds for rehabilitation medicine. It indicates that "without this kind of educational assistance, physical medicine and rehabilitation, as a specialty, would be seriously jeopardized". It also states that current levels of support are not adequate to attract medical students into this field in increasing numbers.

We are attaching a copy of the study "Bulletin #14" by the Commission on Rehabilitation Medicine for insertion into the record if it is not too lengthy.

Program Needs

Two major problems exist in current medical education which have influenced the shortage phenomenon. First, undergraduate medical education does not adequately provide for training and education in the area of physical medicine and rehabilitation. Thus, few undergraduate students become aware of this field of practice and few physicians understand the problems of managing care for the disabled or chronically ill. Second, too few medical schools have departments of physical medicine and rehabilitation and residency programs. Third, there is not enough financial support for residents to stimulate new entrants to the field. Fourth, there are not enough physicians in this field adequately trained to serve in academic medicine as educators and supervisors.

The Bills Pending

H.R. 6802 does not have any new authority to deal with the shortage problems in rehabilitation medicine. While starting new programs is difficult, we would urge that at least a limited authority could be enacted to allow for leadership training in this field of medicine: graduate fellowships for advance training beyond residency programs leading to careers in teaching and research.

We thank you for this opportunity to testify.

National Medical Association NMA

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STATEMENT OF THE NATIONAL MEDICAL ASSOCIATION

RE: Proposed Health Manpower Legislation

HR 6802

to the

Subcommittee on Health and the Environment
of the
Committee on Interstate and Foreign Commerce
United States House of Representatives
Washington, D. C.

April 4, 1980

Mr. Chairman and Members of the Subcommittee:

The National Medical Association, Inc. (NMA) is pleased to have this opportunity to make known its views on the proposed Health Manpower Legislation, namely HR 6802.

As the organization which represents the Nation's 9,300 Black Physicians, NMA is well aware of the overall national health manpower picture, particularly accessible and continuous health care for all Americans is the desired outcome from the proposed health manpower legislation (HR 6802), we have developed our comments on the bill accordingly.

While we touch upon HR 6802's intent to eliminate capitation support for the Nation's health professions schools, we intend to focus upon the adequacy of measures currently in the Federal Health Manpower Legislation and targeted for overcoming the continuing significant underrepresentation of Blacks and other minorities in the Nation's health professions schools.

Targeted Concerns

A. Institutional Support

HR 6802 should include base line funding for each of the recognized schools of medicine and osteopathy, as evidence of national support for physician education in the United States. These funds should be considered as unrestricted block grants to the schools. The level of such funding should be commensurate with the mean level of institutional support which medical and osteopathic schools now receive under existing federal health manpower legislation.

We are not surprised, but dismayed that HR 6802 proposes the elimination of capitation payments to medical schools.

Elimination of capitation is tantamount to the withdrawal of Federal support for medical education. This course of action ignores the fact that medical schools and other health professions schools are national resources in their own right, and among the most costly of all educational institutions, which in many cases are too costly for local governments to maintain without substantial Federal subsidy, or rapidly escalating tuition and fees, given the increasing demands placed upon States and local govenments for other services.

B. Expansion of Minority Group Representation in the Health Professions

NMA, by reason of its composition must always be primarily concerned with the significant underrepresentation of Blacks and other minorities in the medical profession, most especially in the specialties.

The number of Blacks in medical school in the 1968-1969 academic year was 783 or 2.2% of the total enrollment (35,830). By academic year 1974-1975, the Black enrollment had reached 3,355 or 6.3 percent of the total enrollment (46,761). During the last two years (1978-79 and 1979-80) the Black enrollments declined to 5.7% of the total enrollment.

(1) Assistance To Individuals From Disadvantaged Backgrounds

We endorse the provision of HR 6802 (the Waxman Bill) which expands the Assistance To Individuals From Disadvantaged Backgrounds awards under Section 220. Section 782(b) (42 U.S.C. 295g-7(b) of the PHS Act.

We feel that there are far too many Blacks who are academically qualified after the Baccalaureate degree to pursue medicine or osteopathy but who, due to low-income backgrounds and heavy undergraduate debts, abandon this notion.

(2) Financial Assistance for Post Baccalaureate Pre-professional Education

We propose in the same vein that financial assistance be directed to the disadvantaged individuals in need of additional academic training (Post Baccalaureate), in order to meet the basic medical/osteopathic school admissions requirements. Such aid should be directed to the academically able, but debt ridden low-income minority college graduate in order that he/she will be induced to enter medical/osteopathic or other health professions school.

(3) Undergraduate Loan Forgiveness for Successful Matriculation in Professional Schools

There should be a provision whereby upon successful completion of the entry year of health professions schooling, the Government would cancel one third of the debt owed the United States by reason of undergraduate education. Adoption of this type of loan forgiveness would truly expand the pool of Black students who are qualified in every way for medical school admission but who would not apply because of his/her low-income background and extensive undergraduate indebtedness.

While we take cognizance of the desirability of programs calling for payback for medical school scholarships in terms of service in shortage areas. (such as the National Health Service Corps program and the Physician Shortage Area Scholarship program discussed below), there will always be a need for health professions scholarships for students in exceptional financial need who are unable to borrow money for education in the health professions i.e., medicine, osteopathy and dentistry.

Students in exceptional financial need should not, unless they desire the greater financial inducements available through the National Health Service Corps and Physician Shortage Area programs, be required to repay either in money or periods of assigned service the costs of the first year of their medical education.

Summary

The increased accessibility of medical education opportunities for minority and low-income students resulted from the availability of student financial assistance in the form of Federal loans and Scholarships. Continuation of options in the financing of a medical education is the key to achieving equality of opportunity for minorities and the economically disadvantaged in the pursuit of medical education and the practice of medicine.

Today, even though underrepresented minorities accounted for a larger portion of the applicant pool than in past years, a smaller portion of accepted minority students have enrolled.

In the late 1960's, it was believed that the chief barrier for the underrepresented minority groups to a medical education was one of finance.

This was true then and continues to be true now. The decline in this year's acceptances to enter medical schools possibly reflects this significant barrier.

The continued authorizations and increased appropriations with time extensions built in for student financial assistance programs are paramount to the assurance of access to a medical education for the underrepresented populations (Blacks, Chicanos, Puerto Ricans and Native Americans).

There is no easy solution to the complex health professions education financing problems we face today, but if we are to meet the health care needs of the future and thereby assure access and equality of opportunity for meaningful participation by the Nation's underrepresented populations in medicine/osteopathy and the other health professions, we must continue the recognition of the special needs of minority and low-income students and resolve to meet the challenge head on.

In the 1979 medical academic year, the underrepresented minority groups accounted for 9.1% of the total pool attesting to the fact that the interests in the medical profession has not waned among these students. But with continuing inflation, rising tuition costs and decreasing availability of financial assistance options, it is possible that the downward trend in enrollment could continue.

Of these underrepresented minority groups presently enrolled in medical schools, over 30% are participating in a mandatory service obligation type financial assistance program. Programs such as these surely will assist in resolving the problem of maldistribution of physician manpower. However, we must keep in mind that for certain portions of our population, these financing mechanisms are thought of as mortgaging students futures. Thus, it is sometimes at great expense and disadvantage to underrepresented minorities and those who come from low-income backgrounds that these financing mechanisms are accepted.

For the poorest of the poor and those in need of some financial assistance in the pursuit of a medical education, we again appeal to you to provide the means for continued access and equity of opportunity in choice of specialty area and mode of practice in the field of medicine.

In NMA's estimation, reauthorization of low interest loans and scholarship programs with increased appropriations and expanded student support time, as well as, some institutional incentives are essential financing mechanisms for the continued assurance of access and equality of opportunity to the health professions for the economically disadvantaged and minority populations of America.

TESTIMONY OF THE AMERICAN MEDICAL STUDENT ASSOCIATION
SUBMITTED TO THE
U.S. HOUSE INTERSTATE AND FOREIGN COMMERCE COMMITTEE'S
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT HEARINGS ON
HEALTH MANPOWER

We are medical students representing the American Medical Student Association. Because the dates of the hearings fell in the transition period of the presidency following our national convention, we were unable to appear in person. We would like to thank you for the invitation to present the viewpoint of our membership. AMSA has over 20,000 members at 139 medical schools in this country. AMSA is a totally independent organization and we are proud of our record in improving medical education and health care. Many professional organizations gift wrap their own self-interest in the guise of 'the public interest.' We have come here many times in the past; we have made mistakes, but our testimony has consistently been directed toward the good of the society which we hope to serve.

Health manpower legislation, of necessity, covers a broad spectrum. We have targeted our comments to the most critical and relevant issues from a student perspective.

STUDENT ASSISTANCE

This is one of the most serious problems that faces us today. Our profession is in danger of returning to an elitist group of sons and daughters of the wealthy. Recent statistics have shown that students from families with lower middle incomes - the children of farmers, craftsmen, sales clerks, and others in the $10,000 to $20,000 a year range - are gradually disappearing from the nation's medical schools and are being replaced by children of physicians and other affluent professionals. (See attached New York Times article.) Minority admissions have leveled off and as a percentage are actually declining. Some medical schools are beginning to move toward basing their admissions on applicants' ability to pay. (See attached New York Times and The New Physician articles.) One bulletin sent to students recently read in part, "Students with previous educational debts or limited financial resources are especially urged to give full consideration to the selection of ________________ for their medical education. Students may be asked to provide verification of their ability to pay PRIOR to matriculation." (Emphasis added.) This year that school has deleted the sentence "Applicants financial status does not affect acceptance" from the MEDICAL SCHOOL ADMISSION REQUIRMENTS book for all U.S. and Canadian medical schools. Very few students have the luxury of considering which medical school they want to attend other than to the one where they were accepted.

We are not looking for handouts. We know we will be entering a profession that will eventually place us as a group in very high income brackets. We are concerned about trends that will destroy the very altruism that motivated many of us to enter this helping profession. With tuition at $14,500 and allowing a modest $6,000 for annual living expenses students at Georgetown University can graduate with over $80,000 in debts. With the present structure of most of the loan programs many may not even be able to service those debts while in residency training! Theirs is not an atypical situation, we already have reports of several medical residents dropping their training programs because they were unable to meet debt obligations.

In 1975, we came to you and urged you to end capitation payments to medical schools. We said there was no reason for the public to subsidize our education without gaining something in return. We urged you, instead, to provide that money to students for National Health Service Corps scholarships so that they might serve health manpower shortage communities in return for that financial support. Last year our House of Delegates reversed that stand on capitation. They did not do so purely out of self-interest. The phase out of capitation was, in many instances, passed directly on to students. Somehow medical school tuitions are exempt from inflationary guidelines, so that there were tuitions which soared 50-100% in a single year. With cutbacks in all financial aid programs and National Health Service Corps scholarships limited, there is just not the availability of funds for students to meet costs of their education.

What does all this mean? We favor a needs-based financial assistance program to allow all students to cover tuition and living expenses. The question of whether the government should provide that money or merely provide guarantees for increased leverage in the private sector is not an easy one. The former method is the only one that has consistently provided students with assistance. We praise the efforts of the AMA-ERF (Education and Research Foundation), which has attempted to use the latter approach to provide student assistance. The AMA-ERF does not make direct loans to students, but encourages commercial banks to make educational loans available through guarantees, therefore, assuring $12.50 in loans for each $1 it provides. Even this program has been in jeopardy recently because of the moods in banking circles. It has been our experience over the years that using private market leverage has, in many instances, failed the students either because banks don't find students attractive markets, students may have established banking relations with one institution which prohibits them from approaching another, or any interest rate guarantee is so quickly left behind by inflationary spirals that banks limit the funds they will commit to such programs. Medical students do pay back their loans unlike some other groups. The AMA-ERF program has guaranteed over $90 million in loans since

1962 with only a 1.6% default rate, most of which is eventually collectable. Those loans were made at market rates! We use this as an example but we also know that the Health Professions Student Loan program had a similarly favorable record. In summary, the theory of private sector leverage looks good, but it has not served its original intent well. The private market approach usually does not end up serving the needs of low-income and disadvantaged students who often are those most in need of assistance. Perhaps you can restructure such a program to overcome these obstacles, but the financial situation in this country today makes us skeptical. We do favor availability of loans to many rather than subsidized loans to a few.

We think Exceptional Financial Need scholarships are absolutely essential to attract students from lower income brackets into medical schools. Such students may be extremely hesitant to enter into the kind of debts expected especially if they have any concerns about their abilities to survive the rigorous and demanding curriculum. The level of funding of that program last year only provided, at most, one to three scholarships per school. Any cut in this barely acceptable level of funding will no doubt jeopardize those who most need the assistance. We urge that it be expanded.

We strongly support the loan forgiveness for practice in shortage areas concepts. There are many students who want to return to the communities from which they came and will not enter the National Health Service Corps because the lack of assurance of specific assignments. This option is certainly attractive in theory, but I would urge you to look at a twenty-year history of both federal and state loan forgiveness programs. The levels of loan forgiveness for this type provision must be realistic; this is one reason for the many failures of the past. Students $50,000 in debt are not going to consider going to a shortage area where their income, especially in early years of practice, is likely to be meager for two years of $500/month loan forgiveness - the uncertainties are too great. If we want people to enter private practice in shortage areas, loan forgiveness incentives that reflect the risks and difficulties of such undertaking must be provided. Otherwise, we will have another option in the books which no one chooses to exercise. Any loan or loan forgiveness program should reflect an income based repayment schedule if it is to be effective. Upon completion of medical school, students still face a minimum of three and in many instances four to five years of training. Salaries in those years of training and in the first years of practice are not great. For any loan or loan forgiveness program to correct the national needs of specialty and/or geographic maldistribution, it must certainly mean deferment of interest while training continues. Again, I would like to emphasize, we do not want or expect our way to be paid through medical school; but we do not want to drive idealistic physicians into high-paying specialty or geographic areas because the model of medical education in this country has become such an expensive one.

GENERAL INSTITUTIONAL SUPPORT AND SPECIAL PROJECT GRANTS

As we mentioned earlier our House of Delegates last year reversed its stand on not supporting capitation. This was based on the fact that sufficient financial aid was not available and when institutions feel financial uncertainty it is often passed on to students in terms of increased tuitions. It appears that medical schools do need stable financial support. In 1975 we felt that capitation had served its purpose well. It was provided to increase the enrollments in medical schools and over its ten-year history the number of entering medical students doubled.

The important point about capitation, we think, is that it had an original purpose and that purpose was served well. We now have other national priorities, and whether it be called capitation or special project grants, it would seem logical to use this successful model to meet those needs. When the Congress tried to tie some other specific needs to capitation several years ago, several institutions raised the cry of academic independence. Let those institutions who do not want to help us meet our national needs decline those funds. But for those schools who are helping meet those needs, a reflection of stable funding as a quid pro quo would seem to be reasonable. Institutional support should not be based solely upon a medical school's grant writing ability, because we know too well that there are institutions that excell in this special skill. The proverb, "Blessed are the proposal writers, for they shall inherit the grants" has proven too true for our newer community-based medical schools who don't have a research oriented faculty. We also feel that by giving all schools several options for helping to meet national priorities, they will not feel coerced and can make some choices important for themselves.

The history of recent curriculum change certainly reflects the success of special project grants. Many of the sorely needed curriculum changes that have resulted though are mere "add-ons" to an already overcroweded curriculum. Initiatives from the federal government in nutrition, geriatrics, and occupational health have certainly begun to move medical schools in those directions. We feel it is important to also provide special monies for innovative curriculum, not just specific course, changes because the whole model of our medical education is under question. If the physician of tomorrow is to learn to be an advocate for health and not just treat disease, then our education must change. Funds should be available for the schools who want to attempt that challenge. We strongly support the concept of special project monies. Specifically, federal support for family practice and primary care residencies has been responsible for their expansion and the fact that over 50% of graduating students entered those programs last year. Project support for occupational and environmental health courses and residencies, nutrition and preventive medicine courses and residencies, public health graduate programs, preparation for shortage area practice by remote site training, support for shortage area practitioners, increased Area Health Education Centers, and support for developing innovative admissions programs that will increase minority women and rural/inner city applicants are all examples that will move our health care system towards meeting the needs of the society it should serve. Physicians would also be well served to have courses in health policy and epidemiology to understand something of the system they are entering. We feel incentives should be based upon performance, not just opportunity. Forexample, if geriatrics is truly important, then rather than merely offering an elective in geriatrics, a certain percentage of a school's graduating class should have had a course or clerkship in geriatrics. Otherwise we will have "in name only" incentives.

We would like to comment on a couple of critical areas of need. Capitation did increase the numbers of students. Why could such a model not be used to reward and/or attract schools into meeting national priorities of greater enrollment for minorities and women? A few institutions are now bearing the brunt of producing minority physicians. Those institutions are national resources, and recognition of this could be reflected in baseline institutional support based upon their accomplishments. Medical schools with over 12% minority enrollment or over 40% women's enrollment should be recognized for those achievements through additional institutional support beyond capitation. Any institutional financial incentives to attract minorities to medical school will fail unless there is recognition of the need for strong support to increase the minority applicant pool by better preparation and motivation of students at the high school and undergraduate college level. We have spent many millions of dollars in an attempt to do this and it is time we critically evaluated which attempts were successful and which were not. We feel that any institutional support though, should be linked to quid pro quos to direct physician training toward meeting national health manpower objectives.

NATIONAL HEALTH SERVICE CORPS

Earlier, we spoke of our support for an increase in the size of the National Health Service Corps in 1975. We did not mean to imply that was a mistake, but we should reflect upon our lessons from those actions. Scholarships were increased, all other forms of student aid were reduced, and five years later, we see people feeling coerced into the Corps because there were no other alternatives. We also see a majority of scholarship recipients at high tuition schools, most of which institutions have absolutely no commitment to family medicine or primary care shortage area practice. How do we expect those students to adequately prepare themselves for the years of service ahead if their institutions feel no obligation to assist them? In addition, what effects will it have on communities to have physicians who have little commitment to service?

Please do not take these comments to imply any lack of support for the concept or reality of the National Health Service Corps. We are as committed today as we were the first time we came to testify in 1970. There are, however, some problems with the National Health Service Corps, which can be addressed by current legislation. We will not dwell upon those since we testified at recent oversight hearings on the NHSC. We support the continued expansion of the NHSC. We would ask you to be skeptical of those who say it is competing with private practice. At the height of its projected expansion in 1985, it will only have less than 1% of practicing physicians. Surely there is more than 1% of the country that will not support a physician in private practice. We would be skeptical of those who claim that Corps physicians are expensive because they are not as "productive" as private practitioners. These are young Corps physicians practicing in targeted difficult areas, they are often setting up practices or just establishing practice styles, and the populations they serve are often poor and haven't previously had adequate health care—all of which makes for less traditionally objectively defined productivity. We would also be skeptical of those who say Corps physicians are competing with private practitioners in inner city areas. We recall one of the first NHSC inner city shortage designation applications. The local medical society there had initial concerns of competition; they stated that it was one of the most physician-dense areas of the country. However, a woman on Medicaid, describing peptic ulcer disease symptoms, had to call over sixty physicians in this area before she could find one who would treat her. We ask you not to confuse numbers of physicians with access to physicians.

The NHSC needs to attract people who are interested in service, not only financial aid. Having other types of assistance available will help this, because students who want to serve won't have to compete with those who want only aid. Alternatives are needed which recognize that entering medical students cannot make valid choices about primary care when they are as yet unfamiliar with its definition. Options of joining the Corps after or during the third year of medical school when individuals have begun to make meaningful career choices must be allowed. There need to be supports for preceptorship experiences at shortage area sites before students enter the Corps. The Corps itself needs increased funding to provide the communication, nurturance, and preparation of its assignees during the seven years between entering medical school and beginning service in the Corps.

We think the private practice option for National Health Service Corps physicians needs to be fully operational. Many sincere physicians want to return to specific underserved areas that may not have been fully developed as designated Corps sites. We feel that both the community, the physicians, and the ultimate purposes of the Corps can be better addressed with this type option for service.

Medical care for millions of Americans would not be provided without the National Health Service Corps. Over 25% or 700 counties are designated health manpower shortage areas; 138 of those counties have no medical providers at all. We think the 40 million Americans who live in those areas deserve adequate health care and the National Health Service Corps is a proven successful way to provide it.

WE APPRECIATE THE OPPORTUNITY TO SUBMIT THIS WRITTEN TESTIMONY.

Rocio A Huet
ROCIO HUET
President

Charlie Clements
CHARLIE CLEMENTS
Immediate Past President

NEW YORK TIMES 9/30/79

Medical Schools Found Admitting Fewer Lower-Middle-Income Students

By GENE I. MAEROFF

Students from families with lower-middle incomes — the children of farmers, craftsmen, sales clerks and others in the $10,000- to $20,000-a-year range — are gradually disappearing from the nation's medical schools while the percentage of sons and daughters of physicians and other affluent professionals is increasing.

Surveys of entering classes by the Association of American Medical Colleges show that from 1974 to 1977 the number of students from families in the $10,000-to-$16,999 group dropped from 20.9 percent to 14.9 percent and those from the $17,000-to-$20,000 group fell from 13.4 percent to 11.3 percent.

A similar trend is occurring in dental schools throughout the country, according to the American Association of Dental Schools, raising concern among educators in the health professions that students from less wealthy families are possibly being deterred by the high costs from even applying to medical and dental schools.

Median Family Incomes Compared

"We have been fighting for years to broaden the socio-economic level of entering students, but now we are concerned that medicine is going to return to being a profession for the rich," said John A.D. Cooper, president of the Washington-based association.

Although the national median family income in 1977 was $16,009, according to the Bureau of the Census, the median for new medical students that year was $26,000.

Part of the problem is that medical and dental schools are concentrating scholarship aid on the most economically deprived students at the same time that the Government's policy is shifting away from scholarships and toward loans. Affluent students can fall back on family resources, but lower-middle-income students must rely heavily on loans.

Some educators maintain that the high level of debt that such students incur has implications for both where they choose to practice and the specialties they pursue. Under the Government's Health Education Assistance Loan program, a student who borrows $5,000 for each of the four years of medical school and begins a 15-year repayment program after completing his residency — seven years after he got the first loan — ends up paying back $146,700 because of accrued interest, according to the medical colleges association. The interest rate is 12 percent and there is a 2 percent carrying charge. The significance of the amount may be diminished by inflation, but the psychological effect is there nonetheless.

"If a student faces a possible debt of, say, $70,000 the day he walks out of medical school," said Dr. John Rose, the former medical dean at Georgetown University in Washington, where tuition alone has soared to $13,500 a year, "he will go into practice in a place where he can pay off that debt quickest. And that sure as hell is not going to be as a family practitioner in rural America."

Borrowing to the Limit

David Ebert, a third-year medical student at Johns Hopkins University in Baltimore, who grew up on a 40-acre farm in central Ohio, is one of those facing a constant financial struggle. He has borrowed to the limit and both of his parents work, producing a combined income of less than $20,000 a year.

"They have the burden of helping me bridge the gap and they've never complained, but I know they are making sacrifices," said Mr. Ebert, who still has unpaid loans from his undergraduate days at Ohio State University. "It will be a loss if people from my background are squeezed out of medical schools. We have a blue-collar viewpoint that is helpful in empathizing with certain kinds of patients."

Another example of the impact of rising costs was seen recently at Columbia University, where a young Mexican-American had to turn down a coveted acceptance to the medical school to attend a less expensive state-supported school in his home state of Texas. His indebtedness from financing his undergraduate education through loans was already so high that he could get no further credit.

The difference in cost to students at public and private medical schools is substantial, with total costs averaging $10,400 at the independent institutions and $5,012 at the state schools, which charge about an additional $2,000 to out-of-state students.

Fewer at Public Colleges

There are signs, however, that despite lower fees the publicly supported schools are also receiving fewer lower-middle-class students.

For instance, Downstate Medical Center in Brooklyn, a branch of the State University of New York, found that a smaller proportion of its entrants are coming from families in which the students' fathers are clerical and sales workers and small businessmen. Meanwhile, the percentage of students whose fathers are professionals and managerial-level employees has risen sharply.

The College of Medicine and Dentistry of New Jersey, which operates the state's three medical schools and one dental school, has the highest tuition, $3,500, of any of the nation's public schools. Last year, facing further increases, the students persuaded the Legislature that it was in the best interests of the people of New Jersey to cut a projected tuition increase in half.

New York University is a private institution that has resisted the trend and raised the portion of its entering medical school class from the $10,000 to $20,000 background, taking special steps to help this group, which has grown from 11.7 percent of the freshman class in 1976 to 20.3 percent this year.

Assertion Doubted by Some

Spokesmen for medical schools generally insist that family income is not a factor in admissions, but some observers express skepticism and suspect that students from lower-middle-income families may sometimes be at a disadvantage.

"They won't admit it publicly or state it in their catalogues, but some medical schools consider financial background because their financial aid resources are so limited," said Robert Boerner, director of student programs for the Association of American Medical Colleges.

"H.L. Mencken once said that medicine was a rich man's sport and I have been comforted in the last decade that that was past history," said Dr. Henry M. Seidel, associate medical dean at Johns Hopkins. "But I am scared for the future because I don't think we can have a viable system unless we have a strong cadre of physicians from the entire social spectrum."

The New Physician/December 1979

Poor People Need Not Apply

Will Med Schools Restrict Admissions By Bank Balance?

Keith Hoglund

Some medical schools are moving closer to basing admissions on applicants' ability to pay, and one, Loyola-Stritch in suburban Chicago, has adopted perhaps the strongest policy statement in the country on student finances and has already prevented one student from starting classes.

According to Jodie Root, director of admissions at Loyola-Stritch, the financial aid committee met last May and decided that the school had to tighten its policy toward applicants who often assume that the school can guarantee adequate financial aid. In June an admissions information update was printed with a strongly worded warning that Loyola-Stritch could not guarantee full financial aid and in fact might require newly admitted medical students to prove they could meet expenses before starting school.

The bulletin reads, in part: "Students with previous educational debts or limited financial resources are especially urged to give full consideration to the selection of Loyola-Stritch for their medical education. Students may be asked to provide verification of their ability to pay prior to matriculation."

That final statement surprised several financial aid and admission officers at other medical schools contacted by *TNP*. Several said it was a step beyond what any other medical school is doing. Frances French, financial aid adviser at the University of Michigan Medical School and chairman of the Association of American Medical Colleges (AAMC) Committee on the Financial Problems of Medical Students, said that she knows of no other medical school with such a stated policy and that no U.S. med school is using financial status of applicants as an admission criterion. "They are talking about it, but more in terms of 'We hope we never have to do it.' "

Root, too, stressed that student finances are not even considered by the admissions committee at Loyola-Stritch. However, she said the admissions bulletin was intended to force prospective students to consider seriously where they will get the $11,000 plus for yearly tuition, fees, room, and board, and perhaps con-

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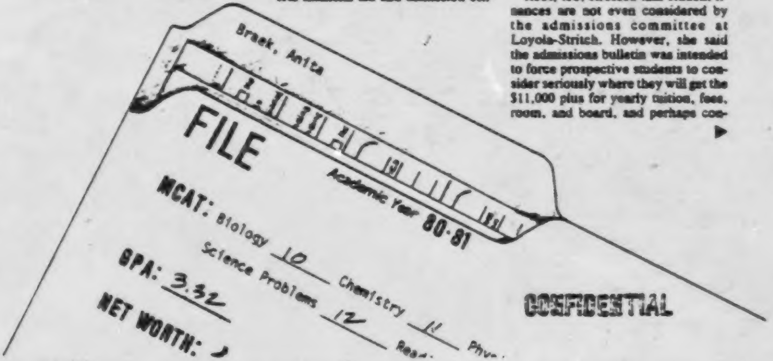

sider a state medical school if they cannot afford Loyola-Stritch.

Root acknowledged that the school last spring considered making financial status an expressed admissions factor but decided against it for fear of its impact on the racial and economic balance of its student body. "It's something we considered and decided we just weren't ready for yet," she said.

Loyola-Stritch's entry in last year's edition of the AAMC's *Medical School Admission Requirements* book for all U.S. and Canadian medical schools included the sentence "Applicants financial status does not affect acceptance." The as-yet-unpublished new edition, admitted Root, no longer contains the sentence, but she insisted that that does not mean Loyola-Stritch will consider financial status in admissions.

Root said that the school's new policy has convinced a few students to go to other schools once they carefully reviewed their financial positions. One student admitted this fall was convinced to delay her studies for one year while she works full time to pay off debts incurred in graduate school. Root called the situation part of "informal policy," but said the woman will not have to reapply for admission next year.

Other schools have been rumored to have crossed the line between warning applicants that money is tight and actually turning away needy students. At least one dental school, Tufts in Boston, has done "financial screening" of applicants for the past three years and "counseled" some to go to less expensive schools, according to a school spokesman.

Two of the most expensive medical schools in the country, Georgetown and George Washington in Washington, D.C., both denied ever having used or planned to use financial criteria in admissions. Spokesmen at the two schools said that financial data on students is channeled to financial aid offices while admissions are decided by a totally separate committee without any knowledge of that data.

Stanford University in California, the medical school after which Root said Loyola-Stritch modeled its financial warnings, claims a similar policy of segregating admissions and financial aid decisions. The school's entry in *Medical School Admissions Requirements* warns that "it has become increasingly difficult to meet all requests for financial aid."

Word spread last winter that the Duke University School of Medicine in North Carolina was turning away applicants because of inability to pay. But Dr. Suydam Osterhout, associate dean for admissions, denies that. What happened, Osterhout told *TNP*, was that when it looked like the Department of Health, Education, and Welfare was about to completely cut off capitation grants to medical schools, as it proposed doing before being overruled by Congress, Duke administrators feared there would be no university funds available for student financial aid. Letters were sent to only 10 already accepted students saying they would have to find much of their financial aid themselves, said Osterhout. But then administrators reversed their decision and sent retractions to those students. Osterhout insisted that financial status has no bearing on medical school admission at Duke and will not in the foreseeable future.

Although apparently no U.S. medical school is confessing to in any way using applicant financial status in admissions, several have considered it and many are talking about it, or at least about how to avoid it. Robert Boerner, director of the AAMC's division of student programs, said he would not go on record forecasting that schools will make finances an admission factor, but that he would not be totally surprised if it eventually happens at some schools, given the current trend toward austerity in medical schools.

Boerner said that even a few years ago when he was an associate dean at a medical school in Pennsylvania, the question would arise within admission committees whether to admit a particularly needy student—one who would require the amount of aid that could meet the needs of two or more other students. "But at that time the answer was always that there was enough money to meet everyone's needs," said Boerner. "It's certainly a different situation [now] from five years ago or even three years ago when most of the schools would say to applicants, 'Don't worry, if you're admitted, we'll find the money for you,' because that kind of guarantee is insupportable today." ●

POSITION PAPER
OF THE
AMERICAN MEDICAL STUDENT ASSOCIATION

Jerry Cade
Doug Outcalt
Jack Rutledge

April 4, 1979

RECOMMENDATIONS OF AMSA

I. Admissions

A. The federal government should financially support the establishment of prototype admission systems which admit to medical schools a percentage of minority, low income and rural students equal to the proportional numbers of each group in the population of the state in which the school is located; and

B. The federal government should establish financial rewards or incentives for those schools which admit and retain large percentages of minority, rural and low income students.

C. The federal government should finance recruitment and educational enrichment programs for minority, low income and rural students in high schools and colleges. These programs should be conducted by private and public organizations and institutions.

D. The federal government should make it illegal for medical schools to accept students based on gifts by applicants or their families.

II. Curriculum

A. In order to produce more physicians who are primary care practitioners, any schools receiving federal start-up grants should be primary care oriented.

B. Federal funds should be provided to support primary care tracks in traditional schools and financial incentives should be offered to schools at a set dollar amount for each student participating in primary care tracks.

C. Federal incentive funds should be provided to encourage medical schools to develop programs and courses in these important areas.

D. A study of the accreditation process by HEW, or its designate, should be carried out to assess the effect of the accreditation process on medical school curricula.

E. A study should be conducted of NIH research support and its effect on medical school curricula and, subsequently, health manpower strategies.

F. In order to meet the increased need for faculty to teach primary care federal support should be offered to institutions for the training of family medicine faculty.

III. Posgraduate Training

A. The Federal government should continue to provide funds for the development and extension of family medicine residency training programs.

B. Until reimbursement trends are substantially altered, some form of external financial support remains necessary for Family Practice training programs.

C. The federal government should support the extension and development of residency programs in primary care internal medicine, primary care obstetrics/gynecology, and primary care pediatrics as a means of achieving this goal.

D. Financial support of current internal medicine, obstetrics/gynecology, and pediatrics programs which emphasize primary care should be continued.

E. Financial incentives should be offered to those medical schools which meet this goal combined with disincentives to prevent schools from meeting the goal by disaffiliating their ongoing non-primary care programs.

F. A study should be conducted to determine the number of specialists and subspecialists required to meet the country's health manpower needs and ways to reduce and control the number of overpopulated specialty and subspecialty postgraduate positions. Authority should be given to the Secretary of HEW to regulate the number of residency positions available in each specialty.

G. All physicians should be reimbursed at the same level for the same primary care service.

H. Payment schedules should be introduced for any necessary services provided by primary care physicians, including preventive services, which are currently not reimbursable.

I. There should be an adequate number of reduced residencies and federal funding should be available for the development of such programs.

IV. Georgraphic Maldistribution

A. Federal funding should be provided for the development of residencies in underserved locations.

B. The reimbursement policies of private health insurance carriers and federal health care programs such as Medicare and Medicaid should be revised to provide for equivalent reimbursement for services rendered regardless of the geographic location of the practitioner.

C. Federal financial support should be provided for start-up grants for rural and inner city group practices.

V. The National Health Service Corps

A. The Corps should be expanded and the necessary federal funds for this expansion should be appropriated.

B. The NHSC needs to expand its technical assistance functions and site preparation and should receive adequate financial support specifically designated for this purpose.

C. Funds should be provided for an expanded and more detailed selection process.

D. Adequate funds should be provided for all of those professional and personal growth experiences.

E. All Corps physicians should be eleigible for incentive pay.

F. Funding should be provided for the NHSC to work with interested states in developing "state service corps scholarships.

G. The costs of state service corps scholarships should be divided between states and the federal government.

H. Each state that attempts to address its own health manpower problems without considering national programs, by means such as forced practice within a state as a pre-requisite for admission to a medical school, should be denied NHSC physicians who have graduated from schools not located in that state.

I. PL 94-484 contains a definition of health manpower shortage areas which includes urban and rural geographic areas, population groups and public, or nonprofit private, medical facilities.

This definition should be continued with two additions:

a. City and county correctional facilities should be eligible in addition to federal and state correctional facilities.

b. The elderly should be considered an eligible population group.

J. The NHSC in its entirety, Scholarship and Field programs should be administered under the Bureau of Community Health Services. The BCHS, being in charge of placement and site development, is the obvious administrative focus for the Scholarship program.

VI. Financing a Medical Education

A. AMSA recommends the establishment of an Educational Opportunity Bank for medical students, established with private trust funds. Government involvement should be limited to start-up assistance and to guarantee against defaults. Loans taken from an E.O. B. should be repaid as a percentage of gross income once a physician is in practice.

An E.O.B. should become self-supporting and repayment should include principle, interest and a participation fee. The interest and participation fee should be based on a progressive, income contingent scale.

B. Until the Economic Opportunity Bank concept is functional, the federal government should continue such low interest loan programs as the Health Professions Student loan and the Federally Insured Student Loan programs. Furthermore, the impractical, high interest loan programs, such as the Health Education Assistance Loan Program (HEAL) should be revamped so that they, too, can provide reasonable sources of money.

C. In addition to the E.O.B. the National Health Service Corps Scholarship program should continue to receive funding. All Public Health Service and military scholarships should be tax exempt.

D. Federal incentive grants should be awarded to medical schools which meet stated manpower objectives. While the majority of funds should properly be appropriated for special grants to individual schools, there may be a role for general grants tied to certain national manpower goals.

E. Safeguards should be established to ensure that tuitions paid for by NHSC or E.O.B. funds do not cover any of these expenses. Tuitions should also be subject to federal inflationary controls.

F. No medical school should be funded or controlled by any military branch of the federal government. The Armed Forces Health Professions scholarship program should be supported as a means of providing volunteer armed forces physicians. The funds currently expended to support a military medical school should be used to upgrade military health facilities, fulfill recruitment promises, and establish financial parity with the NHSC.

G. Medical students oppose any attempt to re-establish a doctor draft.

VII. Americans Studying Aboad

A. All foreign medical graduates, including U.S. citizens studying abroad, should have to pass an examination equivalent to Parts I and II of the National Boards before entering a U.S. postgraduate training program.

B. The Department of HEW should publish statistics on the estimated number of students studying abroad, their chances of returning to U.S. medical training, and their scores on national qualifying exams.

C. No federal program should be established to mandate U.S. schools to accept, as transfer students, U.S. students studying abroad.

VIII. FMG's

A. The provisions of Title VI of PL 94-484 are appropriate and should not be changed.

B. The waiver of requirements provided for in Title VI should not be extended past 1980.

IX. Minorities in Medicine

A. The percentage of minority medical school enrollment should equal the percentage of minoirty representation in the population.

B. Special programs should be funded to train minorities as faculty for medical schools. Financial incentives should be developed to encourage medical schools to increase the number of minority faculty members and administrators.

C. Federal financial assistance should be provided to Meharry and Morehouse Medical Colleges as needed. Howard Medical College should continue to receive funds from the HEW budget.

D. Funding should be provided to establish a Native American Medical School.

E. Also, the scholarship program for students with exceptional financial need should be continued.

X. Women in Medicine

A. Financial support should be provided for recruitment programs at the high school and college levels aimed at increasing the percentage of women applicants.

B. Funding should also be made available for studying the social, cultural, and political factors which impact on an individual's decision to apply to medical school.

C. Federal support should be provided for the training of women as medical school faculty and administrators, and financial incentives should be established to encourage schools to increase the number of women faculty members and administrators.

XI. Physician Competence

A. AMSA recommends that the guaranteeing of a minimum level of physician competence should be more appropriately handled by a national medical board which would establish uniform, national standards for licensure to be enforced by state medical boards while in the process of admitting new physicians to practice in th eir states.

B. AMSA supports a national system of relicensure by re-evaluation with the correction of deficiencies having an emphasis on education and rehabilitatio rather than on punishment. AMSA also urges research on new practice evaluation techniques such as peer review, audits, practice profiles, and computer patient simulation.

C. AMSA supports continuing medical education as a voluntary mechanism for staying current in medical knowledge and urges research in such continuing medical education activities as audits, self-assessments, and patient profiles.

XII. New Health Practitioners

A. The federal government should continue to support the training of physician assistants and nurse practitioners.

XIII. Miscellaneous

A. Grants and contracts for programs in special areas should be financed in order to stimulate their introduction into the curricula of health science schools.

B. Prison Health Care Medical schools should establish linkages with jails and prisons and provide learning experiences for students and housestaff in these settings.

C. Health Team Training--These experiences should be available for health science students and in postgraduate residency programs in primary care specialties.

D. Nutrition--Financial support should be provided for nutrition education only to those schools which meet the following criteria:

1. a separate department or section of nutrition;
2. a separate basic science course in nutrition;
3. a clinical nutrition clerkship;
4. integration of clinical nutrition into the other clinical sciences; and
5. integration of nutrition training into primary care residency programs.

E. Geriatrics--Separate departments of geriatrics need to be established and postgraduate residency programs emphasizing this field should be funded.

F. Preventive Medicine-This important primary care subject should be included in the basic and clinical sciences as well as residency training programs in the primary care specialties.

G. Occupational Health--Funding for these centers should be continued. In addition, programs to integrate occupational health into the basic and clinical sciences of health science schools should be funded.

H. Area Health Education Centers--The AHEC program should be continued and expanded to include more inner-city facilities.

XIV. National Advisory Councils

Advisory Councils dealing with health manpower issues (National Advisory Council on Health Professions Education, National Advisory Council on the National Health Service Corps, the Graduate Medical Education National Advisory Committee, etc.) should consist of representatives from organized medicine, medical education, government (national and state), the public and health science students.

XV. Time Period of Authority

Health manpower legislation should provide authorities for programs for 5 years.

I. Introduction

The American Medical Student Association (AMSA) is a totally independent organization representing 23,000 students at 128 allopathic and osteopathic medical schools. We believe that health care is a right, not a privilege, and that access to minimum standards of health care should be enjoyed by all. During the past ten years, AMSA has attempted to address the issue of health manpower through innovative educational programs and support for various legislation. We have endeavored to expand medical education both directly through curriculum intervention and indirectly through alternative learning experiences. We have placed over 8,000 medical students in migrant camps, on Indian reservations, in Appalachia, and in other rural and urban underserved areas during their summer vacations and elective time. We have also fostered an interdisciplinary approach to the development of health care services and have encouraged positive interactions among health care personnel. As a result of these efforts, we have gained practical experience in what determines the practice locations and specialty choices of young physicians.

We have been active in attempting to increase the representation in medical schools of minority groups and have introduced into medical school curricula courses on topics which need to be addressed such as preventive medicine, nutrition, and geriatrics. We supported the legislation which founded the National Health Service Corps (NHSC) and which implemented the NHSC scholarship program for medical students. We are working with the Indian Health Service (IHS), NHSC and Bureau of Medical Services (BMS) in recruiting physicians and physicians-in-training for those branches of the Public Health Service (PHS). We are presently developing a preceptorship program placing NHSC scholarship recipients in NHSC sites in order to help them better prepare for future practice within the PHS. We remain supportive of the NHSC as a means of realistically confronting manpower needs and will be offering positive recommendations for the Corps' improvement.

It is our belief that any health manpower bill should meet the following objectives:

1) Provide fair treatment of all socioeconomic, cultural, and racial groups with respect to admission to medical school.

2) Develop appropriate incentives to direct medical schools to address national manpower needs through curricular reform.

3) Ensure the production of adequate numbers of primary care practitioners with concommitant reductions in overcrowded specialties.

4) Stimulate a redistribution of physicians such that adequate numbers are directed into areas of critical need.

5) Place the responsibility on students for the financing of their medical education through repayment by service in underserved areas or through direct payment of an equitable share of the true educational costs.

6) Provide for the fulfillment of America's medical manpower needs through the education of adequate numbers of our own citizens for medical careers.

We are aware of the inequities in the current health care system and understand that any improvement is best realized in the public forum relying on information from all people involved—providers, consumers, and federal, state, and local governments. As physicians-in-training we offer suggestions in the areas of admission, curriculum, postgraduate training, geographic distribution, National Health Service Corps, medical education financing, Americans studying abroad, foreign medical graduates, representation of minorities and women, licensure, and allied health. A sincere effort to address these concerns will go a long way toward alleviating the problems that currently exist in health manpower.

II. Admissions

In the continuum of medical education the step most important in determining the types of physicians produced is the admissions system. Unfortunately it is also the most difficult to influence by federal intervention.

Each medical school establishes its own admissions criteria and most consider a number of factors including undergraduate grade point averages (GPA), Medical College Admission Test (MCAT) scores, interviews, letters of recommendation and pastactivities. However, most schools place heaviest emphasis on grades and MCAT scores. As a result of the competitiveness for admission to medical school, the average grade point average and MCAT scores of those admitted have steadily increased.[1]

This type of system discriminates against low income, rural and minority applicants, who generally have lower GPA's and MCAT scores.[2-4] There is strong evidence that minority and rural medical students return to minority and rural communities to practice in much higher percentages than do other students and that background characteristics are the strongest predictors of eventual practice location.[5-11] In addition, there is some evidence that admission systems based on grades and MCAT scores place at a disadvantage those applicants most likely to practice primary care in medically underserved areas and favor those inclined toward research and specialty practice.[12-13]

Most research conducted has shown that grades and MCAT scores do not predict who will make the best physicians.[14-16] Students admitted with low grades and MCAT scores do equally well in clinical training as other students.[17-18]

There are a few schools which have established admissions systems that attempt to correct for the disadvantage faced by minority, rural and low income applicants due to their lower grades and MCAT scores. One example is the Program in Medical Sciences at Florida State University. Each year a large number of minority, rural and low income students is admitted to this program. Each student competes for each place and there are no conflicts with the recent Supreme Court decision in the Bakke case.[19]

It is our strong belief that in order to change the geographic distribution of medical school and residency graduates, it is important to increase significantly the number of medical students admitted from minority, rural and low income groups. Medical schools claim that few students from these groups are accepted because few apply. As we have seen, the standard admission system discourages these students from applying by emphasizing grades and MCATs. History has shown that as educational opportunities for under-represented groups increase, applications then increase, not vice versa.[20] Therefore:

> The federal government should financially support the establishment of prototype admission systems which admit to medical schools a percentage of minority, low income and rural students equal to the proportional numbers of each group in the population of the state in which the school is located; and
>
> The federal government should establish financial rewards or incentives for those schools which admit and retain large percentages of minority, rural and low income students.
>
> The federal government should finance recruitment and educational enrichment programs for minority, low income and rural students in high schools and colleges. These programs should be conducted by private and public organizations and institutions.

As a result of the competitiveness for admission into medical school, there have been several instances reported of applicants gaining admission as a result of large cash payments to schools.[21-22] Medical training is a national resource and not something to be bought by the highest bidder. Therefore:

> The federal government should make it illegal for medical schools to accept students based on gifts by applicants or their families.

We also recognize that women are numberically under-represented in medicine and believe this situation deserves some special considerations which are addressed in the Section on Women in Medicine.

III. Curriculum

An estimated ninety percent (90%) of patient problems can be adequately managed by primary care practitioners.[1] If current trends toward specialization continue, the 1990 physician population will be unable to meet our nation's primary care needs.[2] In order to address this issue, medical schools and medical school curricula must foster an environment conducive to learning and practicing primary care.

We define primary care to include medical care delivery which incorporates and emphasizes the four principles of: first contact; ongoing responsibility; comprehensiveness of scope; and overall coordination of the patient's problems—biological, behavioral and social.

In order to produce more physicians who are primary care practitioners, any schools receiving federal start-up grants should be primary care oriented.

In order to be classified as primary care oriented, schools should meet criteria in the following areas:

1) Percentage of the faculty involved in primary care practice.
2) Percentage of time spent by students in community-based primary care experiences.
3) Equal standing for the Department of Family Practice with other departments.
4) Interdisciplinary learning experiences.
5) Preclinical experiences in primary care settings.

Established medical schools should be encouraged to develop primary care experiences for their medical students. In order to accomplish this

federal funds should be provided to support primary care tracks in traditional schools and financial incentives should be offered to schools at a set dollar amount for each stduent participating in primary care tracks.

There are also numerous emerging areas of national concern related to health that are seldom addressed in medical school curricula. Nutrition, preventive medicine and patient education, aging, the terminally ill, and occupational and environmental health are all topics in which students rarely receive adequate training.

Federal incentive funds should be provided to encourage medical schools to develop programs and courses in these important areas.

The medical school accreditation process, by its forced emphasis on research and specialties, may be producing inhibitory effects on establishing primary care oriented schools and may also be discouraging the exploration of emerging concerns.

A study of the accreditation process by HEW, or its designate, should be carried out to assess the effect of the accreditation process on medical school curricula.

Data is also lacking on the effect NIH research support has on the educational process. We hypothesize that the distribution of funds by NIH allows for power bases among specialties inside medical schools which subsequently exercise a profound influence upon curricular strategy.

A study should be conducted of NIH research support and its effect on medical school curricula and, subsequently, health manpower strategies.

Finally, in order to meet the increased need for faculty to teach primary care,

federal support should be offered to institutions for the training of family medicine faculty.

IV. Postgraduate Training

As a result of federal efforts, there is no longer a problem of inadequate numbers of physicians. Rather, there is a maldistribution of doctors both by specialty and by geographic location.[1] Some measures were taken by the 94th Congress in an attempt to address these issues through affecting postgraduate education; however, insufficient time has elapsed to evaluate their efficacy. The goals established in PL 94-484 of an increased number of primary care physicians and a reduced number of subspecialists remain the key to correction of specialty maldistribution. Many of the programs initiated under that authority and listed below deserve to be expanded and should continue to receive a share of federal expenditures.

Estimates on the need for family physicians approach twenty-five percent (25%) of the total physician population.[2] Currently thirteen percent (13%) of residency positions are filled by students planning to enter family practice and there are indications that this percentage would increase if more positions were available.[3]

The Federal government should continue to provide funds for the development and extension of family medicine residency training programs.

Primary care programs such as family practice provide a wide range of ambulatory services not easily amenable to cost analysis and reimbursement policies. Until reimbursement trends are substantially altered,

some form of external financial support remains necessary for Family Practice training programs.[4]

At least fifty percent (50%) of practicing physicians should be delivering primary care.[5] Family practice programs are currently unable to meet this demand.

The federal government should support the extension and development of residency programs in primary care internal medicine, primary care obstetrics/gynecology, and primary care pediatrics as a means of achieving this goal.

Furthermore, since these three specialties also provide a large range of ambulatory services, they experience the same financial difficulties as family practice.

Financial support of current internal medicine, obstetrics/gynecology, and pediatrics programs which emphasize primary care should be continued.

However, data indicate that pediatrics and particularly internal medicine and obstetrics/gynecology are not currently functioning as training grounds for primary care practitioners.[6-7] An estimated sixty to seventy percent of the graduates from a general internal medicine program opt for additional training in a subspecialty.[8-10] To ensure that these programs do indeed serve to train providers of primary care, criteria should be established which consider the following variables:

1) The percentage of time which must be spent by residents in ambulatory care settings on a continual basis;

2) The percentage of time spent by residents in community-based experiences;

3) The percentage of graduates actually entering primary care;

4) The maximum number of subspecialty fellowship positions allowed at the training institution;

5) Training in preventive medicine as part of the residency program;

6) Interdisciplinary training.

After five years the concept of meeting primary care needs with internal medicine, obstetrics/gynecology medicine and pediatric specialists should be evaluated. If results show that a large percentage of residency program graduates continue to enter subspecialties then federal funds for these programs should be shifted into family practice.

PL 94-484 mandated that fifty percent (50%) of all medical school graduates enter primary care tracks. Again, many graduates enter primary care tracks, but subsequently subspecialize.[11-12] It is more appropriate that fifty percent (50%) of residency graduates be from primary care fields and not going into subspecialties.

> Financial incentives should be offered to those medical schools which meet this goal combined with disincentives to prevent schools from meeting the goal by disaffiliating their ongoing non-primary care programs.

Although the above recommendations will begin to meet our primary care needs, there still remains the problem of too many training programs in certain specialties. Since 1972 we have known that too many surgeons and surgical subspecialists were being trained. Yet there has been no decrease in the number of surgical residency programs.[13]

> A study should be conducted to determine the number of specialists and subspecialists required to meet the country's health manpower needs and ways to reduce and control the number of overpopulated specialty and subspecialty postgraduate positions. Authority should be given to the Secretary of HEW to regulate the number of residency positions available in each specialty.

Current Medicare/Medicaid policies favor specialists by allowing reimbursement levels based upon the prevailing changes of the particular specialty. Thus, primary-care physicians with lower fee schedules receive less compensation for the same procedure than when it is performed by a specialist.[14]

> All physicians should be reimbursed at the same level for the same primary care service.

Many preventive services and other procedures offered by primary care physicians are not reimbursable under Medicare/Medicaid legislation.

> Payment schedules should be introduced for any necessary services provided by primary care physicians, including preventive services, which are currently not reimbursable.

Finally, some medical students have expressed a preference for reduced-schedule residencies as a means of obtaining medical training while pursuing other valued goals.

> There should be an adequate number of reduced residencies and federal funding should be available for the development of such programs.

V. Geographic Maldistribution

With the passage of the Emergency Health Personnel Act in 1970, Congress legislatively recognized the problem of geographic maldistribution. Federal efforts have resulted in a substantial increase in the number of physicians being trained;[1] however, the problem of geographic maldistribution persists.[2] Potential strategies available to address this issue include: the selection of physicians predisposed to enter practice in underserved areas; a medical school environment that suggests practice in rural and inner city locales; and the utilization of incentives to attract physicians to a given region. The first two topics are dealt with in the sections on admissions and curricula.

Physicians show a strong preference for practicing in the location in which they did their posgraduate training.[3] A rational approach to the problem of geographic maldistribution is to preferentially develop new residency positions in the regions where physicians are needed.

> Federal funding should be provided for the development of residencies in underserved locations.

Evidence indicates that Canadian physicians do consider income differentials in deciding where to practice.[4] Whether or not this applies to American physicians is unknown, but we suspect income potential does influence practice locale. Medicare payment levels are currently based on an average of the prevailing charges in the area concerned, and analysis of this data confirms that these levels are lower in rural, underserved localities.[5]

The reimbursement policies of private health insurance carriers and federal health care programs such as Medicare and Medicaid should be revised to provide for equivalent reimbursement for services rendered regardless of the geographic location of the practitioner.

An additional deterrent to practicing in medically underserved areas is the lack of adequate facilities.[5] Most young physicians today do not care to be solo practitioners; they want to practice in groups for a variety of personal and professional reasons.

Federal financial support should be provided for start-up grants for rural and inner city group practices.

This financial support can be repaid as a percentage of the practices' profits over a given amount of time.

VI. The National Health Service Corps

The American Medical Student Association has gained a great deal of practical experience in working with the National Health Service Corps. We have conducted two NHSC preceptorship programs for medical students, have recruited young physicians for the Corps, the Indian Health Service and Bureau of Medical Services, and have conducted conferences for physicians entering the Corps with a service obligation as well as for medical students participating in the scholarship program. We also have placed medical students in medically underserved communities through several projects in which students and communities work together to address local health care problems.

The National Health Service Corps is the best effort to date to address the serious problem of lack of access to medical services by a large segment of the U.S. population.

The Corps should be expanded and the necessary federal funds for this expansion should be appropriated.

The one problem which continues to plague the Corps is the poor retention of physicians. It should be kept in mind that the Corps provides service to a number of areas in which the private physicians are reluctant to practice. There are certain geographic areas which will never attract and retain physicians yet which still need health care. The National Health Service Corps operates in a number of such areas and offers them needed health care even though it is not in the form of permanent physicians.

There are several steps which can be taken to improve the retention rate of Corps physicians. Often communities are not adequately prepared for their role in the operation of NHSC facilities. A successful NHSC site involves a cooperative relationship between health care personnel and communities. Preparatory technical assistance is usually needed to ensure that communities understand their roles and that unrealistic expectations are not present.

The NHSC needs to expand its technical assistance functions and site preparation and should receive adequate financial support specifically designated for this purpose.

The NHSC is becoming increasingly dependent on scholarship recipients as a source of physician personnel. Due to the increasing costs of medical education and decreasing sources of alternative funding, many students are applying for NHSC scholarships out of financial necessity rather than a desire to serve. The priority in awarding scholarships goes to first and second year students, and no real effort is made to distinguish those with a desire to serve from those who are in financial need. The three schools with the highest number of scholarship recipients are Georgetown, George Washington, and Meharry. The first two schools have the highest tuition in the country and the third has a student body made up of predominantly disadvantaged students.

Once medical students are accepted into the scholarship program they receive little information from the Corps as to what to expect in later years. These scholarship recipients attend traditional medical schools which shunt students toward specialties and do not prepare them for future practice in medically underserved areas. Those recipients not committed to the Corps will tend to fulfill their service obligation after one year of internship and then leave to complete a residency. Once scholarship recipients begin to repay with service, they find out that their salaries are substantially below that of their volunteer colleagues because of their ineligibility for incentive pay.

It is clear that retention could be improved with a few major changes. Only those students with a desire to practice in medically underserved areas should be accepted into the scholarship program. A restructuring of the current financing of medical education is necessary so that there are acceptable funding options present for those not inclined toward service. This problem is addressed in detail in the section on Financing Medical Education.

> Funds should be provided for an expanded and more detailed selection process.

Once accepted into the scholarship program students should receive periodic communications from the Corps helping them understand and prepare for their eventual practices. Conferences need to be held on a periodic basis to acquaint students with other scholarship recipients and with NHSC personnel. Learning opportunities at NHSC sites need to be developed and maintained so that students can experience the clinical and nonclinical aspects of Corps practice.

> Adequate funds should be provided for all of those professional and personal growth experiences.

This will demonstrate an interest in and commitment to scholarship recipients by the Corps. It will help restore the scholarship program to one of service, will cost a small fraction of the current Corps budget and will result in improved satisfaction on the part of Corps physicians. In addition,

> all Corps physicians should be eligible for incentive pay.

Since the passage of PL 94-484 there has been some confusion as to the benefits which other federal health services will receive from the NHSC scholarship program. The Indian Health Service and Bureau of Medical Services also have unmet manpower needs and should continue to be service options for those scholarship recipients who desire such service.

In recent years many state legislatures have taken an interest in their states' health manpower problems. Most legislatures want to see the graduates of their medical schools stay within the state to practice. This is an understandable attitude but ignores citizens' right to mobility and also frustrates national health manpower strategies. The problem of medically underserved populations should be addressed as a joint federal/state effort. States should be encouraged to work with federal programs like the National Health Service Corps.

> Funding should be provided for the NHSC to work with interested states in developing "state service corps scholarships."

These scholarships would be for medical students attending each respective state's public and private medical schools.

> The costs of state service corps scholarships should be divided between states and the federal government.

The NHSC should then cooperate with state governments to place these scholarship recipients within health manpower shortage areas within each respective state.

Each state that attempts to address its own health manpower problems without considering national programs, by means such as forced practice within a state as a pre-requisite for admission to a medical school,

> should be denied NHSC physicians who have graduated from schools not located in that state.

II. Designation of Health Manpower Shortage Area

PL 94-484 contains a definition of health manpower shortage areas which includes urban and rural geographic areas, population groups and public, or nonprofit private, medical facilities.

> This definition should be continued with two additions:
>
> A. City and county correctional facilities should be eligible in addition to Federal and State correctional facilities.
>
> B. The elderly should be considered an eligible population group.

Finally, the divided administration of the Corps program is complicated and confusing. Currently, the Bureau of Health Manpower has authority over the Scholarship program whereas the Bureau of Community Health Services oversees the Field program. Students who are scholarship recipients or who are considering applying for scholarships by necessity will have numerous questions about site availability, future plans for the Corps, matching of site and scholarship recipient, and various other issues dealing with their future service. In many cases the staff of the Scholarship program is unable to answer these questions and must direct these students to an entirely different Bureau, causing undue confusion and frustration.

> The NHSC in its entirety, Scholarship and Field programs, should be administered under the Bureau of Community Health Services. The BCHS, being in charge of placement and site development, is the obvious administrative focus for the Scholarship program.

II. Financing Medical Education

Medical Student Loans and Scholarships

Before discussing recommendations concerning methods of financing medical education, it is important to understand the premises on which this discussion will be based.

1) It is not unreasonable for taxpayers to expect medical students to assume a large share of the costs of their educations. The medical profession is one of the highest paid in the country, yet medical student tuition accounts for only a small share of the costs of medical education.[1] Low tuitions are not only public subsidies of the future rich but are also public subsidies of those medical students currently in upper income brackets who could afford to pay for their educations.[2]

2) It is not unreasonable to expect those who cannot afford the costs of a medical education to secure loans to help meet these expenses.

3) It is unreasonable to expect these loans to be repaid while one is in internship or residency training or in the early years of practice. This is a time when physicians are not well off financially.

4) The National Health Service Corps Scholarship is a perfectly reasonable mechanism to provide a medical student with financial support in exchange for a future service commitment in a medically underserved area. However, students should be able to choose this option, not be forced into it as a result of a lack of financial alternatives.

5) Medical education should be available to all income groups and federal policies should not provide disincentives to potential medical students from low income groups.

The current system of loans and scholarships available to medical students is less than ideal. The various loan options require repayment during residency training and/or in the first years following residency. Currently 55% of first-year medical students expect debts of $15,000 or more at the end of medical school. 15% expect debts of over $30,000.[3] The specter of such large debts and accrued interest along with the limited time for repayment is forcing many students to accept service-dependent scholarships.

The five schools with the largest number of new NHSC scholarships awarded in 1978 were Meharry, Georgetown, George Washington, Jefferson and Tufts. All are expensive private schools except for Meharry, which enrolls a large number of financially disadvantaged students. In addition, 30% of recent NHSC scholarships have been awarded to minority students who represent only 9-10% of the total medical student population, indicating that this group is having to assume an inequitable share of the service commitment.

This situation does not bode well for the National Health Service Corps. It would be better to have a small NHSC with committed physicians than a large NHSC with physicians who have "forced service" attitudes.

As one solution to the problems of loan repayment during residency and the inappropriate use of the NHSC. AMSA recommends the establishment of an Educational Opportunity Bank for medical students, established with private trust funds. Government involvement should be limited to start up assistance and to guarantee against defaults. Loans taken from an E.O.B. should be repaid as a percentage of gross income once a physician is in practice.[4-6] This would allow students to assume more responsibility for the costs of their medical education yet provide a less burdensome mechanism for repayment. It would provide a true alternative for those not desiring a service-commitment scholarship yet still provide incentives to accept NHSC scholarships. At the same time, income contingent repayment provides no disincentive for establishing a low paying practice in a medically underserved area. An E.O.B. should become self-supporting and repayment should include principle, interest and a participation fee. The interest and participation fee should be based on a progressive, income contingent scale. It should also be possible for a percentage of the debt to be forgiven each year for service in the NHSC. Potential medical students from low income families should find this mechanism of repayment more attractive and should not be deterred from entering medical school.

Until the Economic Opportunity Bank concept is functional, the federal government should continue such low interest loan programs as the Health Professions Student Loan and the Federally Insured Student Loan programs. Furthermore, the impractical, high interest loan programs, such as the Health Education Assistance Loan Program (HEAL) should be revamped so that they, too, can provide reasonable sources of money.

In addition to the E.O.B. the National Health Service Corps Scholarship program should continue to receive funding. All Public Health Service and military scholarships should be tax exempt. It is anticipated that with an E.O.B. program the demand for NHSC scholarships will continue to be high although not at the same level as the past few years.

Incentive Grants/Capitation Funds

The role of capitation grants has recently been increasingly questioned and criticized. Historically, these grants have been utilized to achieve perceived national manpower goals; for example, in 1971 these funds were tied to a requirement that each medical school increase its class size and thus fulfill the then perceived need for more physicians.

More recently capitation grants have not been used effectively to encourage schools to address current health manpower goals. Whatever the form or name - capitation, incentive grants, or special project grants - these federal monies should be tied to the achievement of national health manpower needs.

Special incentive grants should be available to each individual school if that school meets specific goals or criteria. Such special grant goals would include developing and expanding family practice training programs, establishing Departments of Family Medicine, recruiting and retaining under-represented groups such as minority and rural students, and developing curricular innovations in areas like geriatrics, nutrition, and occupational health.

Other national health manpower objectives may best be affected by providing general incentive grants. These grants would be provided to each school as long as specified manpower goals were met nationally. If these goals were not met nationally, only those schools which individually met the goals would receive funds. One such national manpower objective would be a specific percentage of graduates from primary care residencies.

Federal incentive grants should be awarded to medical schools which meet stated manpower objectives. While the majority of funds should properly be appropriated for special grants to individual schools, there may be a role for general grants tied to certain national manpower goals.

Tuition Levels

While it is not unreasonable to expect medical students to pay for a larger share of the costs of their educations, it is unreasonable to expect them to pay for noneducational expenses. Medical students should not have to pay for the costs of training graduate students, budgetary inefficiency or noneducationally related research. Safeguards should be established to ensure that tuitions paid for by NHSC or E.O.B. funds do not cover any of these expenses. Tuitions should also be subject to federal inflationary controls.

Military Physicians

Military physicians should be trained by civilian medical schools in order to avoid a small military medical "elite". No medical school should be funded or controlled by any military branch of the federal government. The Armed Forces Health Professions scholarship program should be supported as a means of providing volunteer armed forces physicians. The current problem of a physician shortage in the armed services is, candidly, the military's own fault. Overstated promises by recruiters and a lack of responsiveness to physicians' needs have given the military a bad name among medical students. The funds currently expended to support a military medical school should be used to upgrade military health facilities, fulfill recruitment promises, and establish financial parity with the NHSC.

Medical students oppose any attempt to re-establish a doctor draft. However, if such a proposal is considered, it should provide for a choice between military service and civilian service in a medically underserved area.

IX. Americans Studying Abroad

One of the more difficult problems in establishing a national health manpower policy is determining how to respond to U. S. citizens studying medicine in foreign countries. A large number of Americans studying overseas undermines any attempt at health manpower planning. The U. S. should take the responsibility to train sufficient numbers of physicians within the U. S. to meet national needs. It is not possible to prevent students from studying medicine abroad; however, several steps can be taken to discourage students from choosing this option.

In order to qualify for an exchange visa to study in a U. S. residency program, a F.M.G. must pass a Visa Qualifying Exam (V.Q.E.). This requirement does not apply to U. S. students studying abroad. They must pass only the ECFMG exam, which is half as long and twice as easy. The V.Q.E. was established in P.L. 94-484 in order to ensure an adequate level of knowledge by F.M.G.'s entering this country for postgraduate training. Americans studying abroad should possess the same level of knowledge. All foreign medical graduates, including U. S. citizens studying abroad, should have to pass an examination equivalent to Parts I and II of the National Boards before entering a U. S. postgraduate training program.

Many Americans travel overseas to study medicine without knowing their chances of returning to a U. S. school or postgraduate training program. The Department of H.E.W. should publish statistics on the estimated number of students studying abroad, their chances of returning to U. S. medical training, and their scores on national qualifying exams. These statistics should be widely disseminated to premedical advisors.

Many medical schools accept U. S. citizens studying abroad as transfer students. Medical schools should be allowed to decide whether or not to accept U. S. citizens studying abroad and to utilize their own admissions criteria in accepting these transfer students. The "Guadalajara Clause" contained in PL 94-484, which mandated U. S. schools to accept U. S. students studying abroad as transfer students, seemed to encourage Americans to study medicine overseas. No federal program should be established to mandate U. S. schools to accept, as transfer students, U. S. students studying abroad.

X. FMG's

The U. S. should fulfill its own medical manpower needs through the education of its own citizens for the practice of medicine and should stop the ethically questionable practice of recruiting physicians from other countries.

We should offer truly educational opportunities to foreign trained physicians at an appropriate level and in appropriate specialties, so that these physicians can return and function in their countries' health care systems. Title VI of the Health Professions Educational Assistance Act of 1976 (PL 94-484) implements requirements which exchange visitors must meet before entering a U. S. postgraduate training program. The training program must be affiliated with a U. S. medical school; the physician must pass an English proficiency exam and a Visa Qualifying Exam (equivalent to Parts I and II of the National Boards); he/she must return to their country upon completion of training; and he/she can remain in the U. S. for a maximum of three years of training.

The provisions of Title VI of PL 94-484 are appropriate and should not be changed.

There is evidence that certain postgraduate training programs would suffer a disruption of medical services if Title VI were implemented immediately.[1] A waiver of certain requirements through 1980 for such programs is provided by PL 94-484. With this waiver these programs should be able to adjust accordingly to meet service needs by substitution of nonphysician personnel and/or by converting certain specialty training programs to primary care programs, which in turn would attract larger numbers of American graduates.[2]

The waiver of requirements provided for in Title VI should not be extended past 1980.

XI. Minorities in Medicine

The under-representation of minority students in medical schools continues. In fact, the previous gains in increasing the percentage of medical students from minority groups have ceased. Minority representation in medical schools has leveled off at 8.1%[1,2]. This figure is particularly bothersome when one realizes that 20% of minority students are attending predominantly minority schools. Increased representation of racial minority students is desirable not only because of a concern for social equity but also because such representation leads to positive and necessary changes in the attitudes of students and faculty toward minority groups. In addition, minority physicians tend to practice in medically underserved minority communities.

The percentage of minority-medical school enrollment should equal the percentage of minority representation in the population. This should be accomplished by the mechanisms stated in the section on Admissions. There are several other steps which should be taken. Special programs should be funded to train minorities as faculty for medical schools. Financial incentives should be developed to encourage medical schools to increase the number of minority faculty members and administrators.

Federal financial assistance should be provided to Meharry and Morehouse Medical Colleges as needed. Howard Medical College should continue to receive funds from the H.E.W. budget. These schools currently train a significant proportion of the nation's minority physicians. In addition, funding should be provided to establish a Native American Medical School.

There should be no financial barriers to potential minority medical students. The development of an Educational Opportunity Bank (E.O.B.) (section on Financing Medical Education) would help eliminate these barriers. Also, the scholarship program for students with exceptional financial need should be continued.

XII. Women in Medicine

Women represent 51.1 percent of the Unived States population.[1] A long term national goal to include a commensurate percentage of women in the physician population is both reasonable and desirable.

The acceptance rate for female applicants reflects their percentage of the applicant pool.[2] One approach, then, is to increase the number of female applicants.

Financial support should be provided for recruitment programs at the high school and college levels aimed at increasing the percentage of women applicants.

Funding should also be made available for studying the social, cultural, and political factors which impact on an individual's decision to apply to medical school.

Finally, a convincing hypothesis is that the stability of women in the medical profession is dependent upon their integration into faculty and administrative positions.[3]

Federal support should be provided for the training of women as medical school faculty and administrators, and financial incentives should be established to encourage schools to increase the number of women faculty members and administrators.

XIII. Physician Competence

Physician licensure, specialty board certification, continuing medical education, and medical discipline are all components of the complex approach taken in the United States to assure to the public the competence of physicians. Due to the rapid rate at which new medical knowledge is gained, there has been much debate on the need for relicensure or required continuing medical education to ensure the continuing competence of physicians. The laws pertaining to physician competence have undergone substantial developments during the past decade yet many additional changes are needed. AMSA believes many of these should be enacted on a national level.

The system of licensure as it is currently set up is neither a true state nor national system. National examinations are used, yet different levels of performance are accepted by individual states. State medical boards are currently attempting to accomplish two functions simultaneously: guaranteeing minimum levels of physician competence and admitting new physicians to practice in the state. AMSA recommends that the guaranteeing of a minimum level of physician competence should be more appropriately handled by a national medical board which would establish uniform, national standards for licensure to be enforced by state medical boards while in the process of admitting new physicians to practice in their states.

Relicensure implies re-evaluation for continuance of licensure and should not be confused with reregistration of licenses which involves simply reapplying and paying a reapplication fee. Considering the rapidity with which new medical knowledge is discovered and technology developed, it is difficult to argue against some kind of periodic re-evaluation of physicians. The public seems to be developing an increasing awareness of the presence of incompetent and/or out-of-date physicians and there have been several government proposals for relicensure. The question is no longer whether or not relicensure is desirable, but instead what form it should take. AMSA supports a national system of relicensure by re-evaluation with the correction of deficiencies having an emphasis on education and rehabilitation rather than on punishment. AMSA also urges research on new practice evaluation techniques such as peer review, audits, practice profiles, and computer patient simulation.

Continuing medical education (CME) currently involves attending educational courses and participating in other educational activities in an attempt to keep up-to-date on medical knowledge. There are numerous problems with the existing system of CME including the questionable effectiveness of the lecture format, the lack of evaluation components in the courses, and the disturbing number of ski trips and luxury-liner cruises that are included, all of which are tax deductible.

AMSA supports CME as a voluntary mechanism for staying current in medical knowledge and urges research in such CME activities as audits, self-assessments, and patient profiles.

XIV. New Health Practitioners

The last decade has seen the use of two new professional groups - physician assistants and nurse practitioners. Approximately seventy percent (70%) of these new health professionals are involved in delivering primary care.[1] They have been shown to increase the productivity of primary care practice units and allow more time for the physician to practice skills unique to him/her.[2] Perhaps more importantly, utilization of new health practitioners has resulted in a reduction of costs.[3]

The Federal Government should continue to support the training of physician assistants and nurse practitioners

XV. Miscellaneous

Grants and contracts for programs in special areas should be financed in order to stimulate their introduction into the curricula of health science schools. Medical and other health science institutions have been slow to change their curricula to meet the needs of the public. It has often taken activity by private organizations and the government to provide the stimulus for change. Therefore, these grants and contracts should be available to health science institutions and to public, non-profit organizations.

Prison Health Care - The populations of jails and prisons remain one of the most medically underserved in the country. Clinical experiences should be established for health science students inside jails and prisons. Medical schools should establish linkages with jails and prisons and provide learning experiences for students and housestaff in these settings.

Health Team Training - Interdisciplinary learning experiences are necessary to foster positive working relationships between different health care practitioners. These experiences should be available for health science students and in postgraduate residency programs in primary care specialties.

Nutrition - Every health practitioner, especially those in primary care, should know the basics of nutrition and be able to apply these to the daily practice of medicine. Medical and other health science schools have relegated nutrition to a low priority and few if any provide their students with adequate education in this area.[1]

Financial support should be provided for nutrition education only to those schools which meet the following criteria:

1. a separate department or section of nutrition;
2. a separate basic science course in nutrition;
3. a clinical nutrition clerkship;
4. integration of clinical nutrition into the other clinical sciences; and
5. integration of nutrition training into primary care residency programs.

Geriatrics - Currently over 10% of the U. S. population is over the age of 65. This group occupies 33% of our hospital beds and 95% of long term beds. They make more office visits than any other age group. 30-40% of a family physician's time is spent treating the elderly yet very few health science schools deal effectively with the special problems of the aged in their curricula.

The health problems of the aged should be taught in the basic and clinical sciences as well as in the postgraduate residency programs in primary care specialties (except, of course, pediatrics). Separate departments of geriatrics need to be established and postgraduate residency programs emphasizing this field should be funded.

Preventive Medicine - This important primary care subject should be included in the basic and clinical sciences as well as residency training programs in the primary care specialties.

Occupational Health - PL 94-484 established regional occupational health training centers to provide training for health science students in the area of occupational health and to establish occupational health residency programs. Funding for these centers should be continued.

In addition, programs to integrate occupational health into the basic and clinical sciences of health science schools should be funded.

Area Health Education Centers - A.H.E.C.'s provide a valuable link between medical schools and community facilities, serving as a resource in training health students and residents in remote sites and providing continuing education for health professionals.[2] The AHEC program should be continued and expanded to include more inner-city facilities.

National Advisory Councils

Advisory Councils dealing with health manpower issues (National Advisory Council on Health Professions Education, National Advisory Council on the National Health Service Corps, the Graduate Medical Education National Advisory Committee, etc.) should consist of representatives from organized medicine, medical education, government (national and state), the public and health science students. Not more than 50% of the members on each committee should be representatives of organized medicine and medical education.

Time Period of Authority

Health manpower legislation should provide authorities for programs for 5 years. Three years is simply too short of a time period to evaluate programs and make recommendations for changes.

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MOREHOUSE COLLEGE SCHOOL OF MEDICINE

MR. CHAIRMAN AND DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE:

I am Dr. Louis W. Sullivan, Dean and Director of the School of Medicine at Morehouse College. I am grateful for the opportunity to share with you my views concerning the renewal of Health Manpower Legislation.

The primary focus of my comments will be on ways in which the Federal Government can assist a new two-year school of basic medical sciences, such as the School of Medicine at Morehouse College in its efforts to train more primary care physicians for work in underserved rural areas and the inner cities.

First, I wish to share with you some information about the School of Medicine at Morehouse College.

A. MOREHOUSE COLLEGE

Morehouse College is a liberal arts institution, in Atlanta, Georgia. For more than 113 years this institution has provided quality education to a predominantly black student body, and has enabled its graduates to pursue successful careers and leadership roles in American society. It has a long list of distinguished alumni: Martin Luther King, Jr. (Nobel Peach Prize Winner); Martin Luther King, Sr.; The Honorable Maynard Jackson (Mayor, City of Atlanta); The Honorable Julian Bond (Georgia State Senator); Lerone Bennett (Senior Editor, Ebony Magazine); and many more.

Morehouse College has provided the undergraduate education for more college presidents, more Ph.D.'s, more physicians, more dentists, more lawyers, more MBA's, more bank presidents -- than any other predominantly black college in the United States of comparable size. The reason is the College's heritage of academic quality. Morehouse is one of only four Georgia educational institutions with a chapter of Phi Beta Kappa. Morehouse's contribution to the science and health manpower pool in this country has been, and continues to be, outstanding. Of the College's 4,500 alumni, 8% are physicians, dentists, or holders of a Ph.D. in a science discipline. Of some 6,600 black physicians in the United

States, more than 6% are graduates of Morehouse College.

B. THE SCHOOL OF MEDICINE

Because of the College's commitment to better serve the health care needs of the nation's poor and minority citizens, the College received, in February, 1973 and in July, 1974, federal assistance for the design and development of a two-year program in basic medical sciences education that would be responsive to the needs of under-represented minorities and low income students.

The School of Medicine at Morehouse opened in September, 1978 as a two-year school of basic medical sciences with a charter class of 24 students. The School of Medicine at Morehouse College is the first medical school to be founded by a minority institution in the twentieth century.

The School of Medicine at Morehouse College has a primary mission to educate and train students from disadvantaged backgrounds for medical careers as primary care physicians (family practitioners, general internists, general pediatricians, etc.), to work in medically-underserved rural and inner-city communities, with poor and disadvantaged populations.

Because of the School's commitment to develop a medical-education program to better serve the health care needs of the nation's poor and minority citizens, the School has received endorsements of support from the Honorable Jimmy Carter; for the Secretary of the Department of Health, Education and Welfare, the Honorable Joseph Califano; the National Medical Association; the American Medical Association; the Medical Association of Georgia; the Georgia State Medical Association; the Association of American Medical Colleges; the Honorable George Busbee, Governor of the State of Georgia; the Georgia Legislature; the Mayor of Atlanta; the Fulton County Commission; the Atlanta Chamber of Commerce; and the Carnegie Council.

The efforts by the School of Medicine at Morehouse College were cited in the Health Professions Educational Assistance Act of 1976:

> "The Committee intends for the program to initiate new health professions schools to be redirected to assist in the alleviation of the specialty and geographic maldistribtuion of health professionals. It is not enough simply to train more health professionals. The additional professionals must be in appropriate fields and practice in areas where they are needed. The Committee expects that assistance will go to new schools which actively seek to train professionals for practice in the primary care medical specialties and in areas which are less well served. The Committee believes that schools which are organized in new ways and whose curricula vary from the traditional pattern are now more likely to produce the new practitioners so needed by the nation. The program now being developed at Morehouse College is an example of the sort of program which will be supported by the revised startup authority."

The plans of the School of Medicine at Morehouse College are to develop from a two-year school of basic medical sciences to a four year M.D. degree granting institution by 1985. (i.e., the entering class of September 1981 will be the first class to complete their entire undergraduate medical education program within our institution).

It is in the context of both commitment and challenge that I am pleased to submit this testimony. Commitment to the goal of becoming a leader in medical education in the U.S.; to discover and promulgate new biomedical knowledge; to find better ways to organize and to deliver health care in a more humane, cost-effective and efficient manner; to provide more emphasis on preventive measures, health promotion and the conservation of health in the general population.

Our charter class of 24 students will be transferring in the summer of 1980 to affiliated medical schools at Emory University, the Medical College of Georgia, Howard University, Meharry Medical College and the University of Alabama at Birmingham.

The School of Medicine has a total of 26 full-time faculty in the basic medical sciences (anatomy, biochemistry, physiology, pathology, pharmacology, behavioral sciences), in the clinical sciences of internal medicine, community medicine/family practice and psychiatry.

The projected school enrollment, by class and by year, is shown in Table I. It should be noted that pending approval from the Liaison Committee on Medical Education, the class enrollment for September, 1980 is expected to be increased to 32 students. According to the anticipated increase in our enrollment, the initial third year class of the School of Medicine at Morehouse College will be 48 by 1983.

The need for greatly increased numbers of under-represented minorities in medicine and other health sciences is a national need which must be met with national resources. Therefore, the School of Medicine at Morehouse College strongly supports the recommendations from the Consortium of Minority Health Professions Schools, and, urgently recommends that these proposals be included in the reauthorization of the Health Manpower Act.

However, as a developing basic medical sciences school, which opened in September, 1978, the School of Medicine at Morehouse College, like previous new two-year medical schools, has particular needs for facilities and conversion support for the development of the third and fourth clinical years.

C. FACILITIES FOR MEDICAL EDUCATION

The School of Medicine at Morehouse College is currently housed in interim facilities loaned by Morehouse and located on the Morehouse College campus. The classrooms, first year student laboratories and some faculty and administrative offices are housed in Sale Hall (circa, 1910); second year student laboratories and faculty research laboratories are housed in a newly constructed pre-engineered temporary building; additional faculty offices are in a renovated apartment building; the medical library is on the ground floor of Brawley Hall, a College classroom building; and remaining administrative offices are in Harkness Hall (circa, 1936), an administrative office building shared with Atlanta University.

The School of Medicine has recently raised sums for the purchase of 6.3 acres of land, adjacent to the Morehouse College campus, to serve as the basic science campus of the medical school.

Ground-breaking ceremonies to initiate the construction of the first phase of the basic medical sciences building will take place on April 18, 1980 in Atlanta, and we welcome the subcommittee's participation at these ceremonies. This $6.25 million building will have some 67,000 net square feet for classrooms, student laboratories, faculty offices and laboratories, student lounge, medical library and some administrative offices. The construction of the second phase of the basic medical sciences building, which will have approximately 80,000 square feet, is scheduled to be initiated in 1981, to allow for expansion of class size to 80 students; and to provide additional space for faculty offices and laboratories, administrative offices and support services.

In order to maintain accreditation and to provide the best possible academic environment, it is imperative that construction of needed facilities proceed as soon as possible.

We would like to thank you, Mr. Chairman, and distinguished members of the Subcommittee for the construction funds which have been awarded to the School thus far. They have been invaluable to our institution.

In order for us to continue with our plan for orderly development, and for the School to maintain its accreditation, we must have funds for additional construction of needed facilities.

I recommend to the members of this Subcommittee the addition of authority for the construction of medical education facilities for new two-year medical schools. The suggested language for these sections is:

> "The Secretary may make grants to Schools for:
>
> 1) The construction of facilities for use in the training and research activities of allopathic physicians, osteopathic physicians, dentists, veterinarians, optometrists, podiatrists, pharmacists, and professional public health personnel if, in the fiscal year ending September 30, 1978 or thereafter, such school received or was eligible to receive start-up assistance grants under either Section 788(g), (as it existed prior to October 1, 1980)."

2) For grants under this Section there is authorized to be appropriated $10,000,000 for the fiscal year ending September 30, 1981 and for each of the succeeding three fiscal years."

3) In considering applications for grants under this Section, the Secretary shall give just consideration to applications submitted by medical schools for the expansion of a two-year program to a degree granting program, and by new schools that anticipate a predominantly minority student enrollment."

D. CONVERSION TO A FOUR-YEAR MEDICAL SCHOOL

Conversion support must be available if we are to succeed with the required development of the third and fourth years of medical education, as required by the Liaison Committee on Medical Education (LCME).

Conversion support would assure the successful development of a four-year degree-granting program at Morehouse and would help to guarantee the realization of our institutional mission -- to assist the nation in its efforts to increase the numbers of minority physicians for service as primary care practitioners in under-served areas.

Precedent for conversion support exists in Public Law 92-157, and has been instrumental in the development of other similarly situated medical schools in the past. Therefore, we urge the Subcommittee to approve conversion support.

We recommend to the Subcommittee the addition of a section on conversion funds for new two-year schools of medicine to assist them to become an M.D. degree granting institution, as required by the accreditation committee (LCME). We propose the following language for this section:

> "The Secretary may make a single grant to a public or non-profit private two-year school of medicine that intends to become a school accredited to grant the degree of doctor of medicine. The amount of the grant to a school under this section shall be equal to the product of $50,000 and the number of third-year students that will be initially enrolled in such school. No school may receive more than one grant under this section."

Upon request of the school, a grant received under this section may be used in the year preceding the initial enrollment of third-year students in such school."

E. COMMENTS

This leadership support from the Federal Government is justified by the fact that the School of Medicine at Morehouse College is an institution which will serve the entire nation, and was developed in response to a national need for more primary care physicians, to work in underserved areas, among our disadvantaged, poor, and minority citizens.

This support will allow our developing medical school to continue with its orderly development, and to acquire the needed facilities to insure that its educational environment will be of outstanding merit. Further, significant matching support from the private sector for program, land, facilities and the developments of an endowment will be made possible once we have received significant Federal support.

This bold initiative by a minority institution in response to a national need (for more minority physicians to work in underserved ares) deserves to be supported, as do other similarly situated institutions. Without such support, the full development of the contribution of the School of Medicine at Morehouse College to our nation's urgent health care needs will not be realized.

It is to meet this challenge that we urge your action and your support. This national need must have a national response.

F. SUMMARY

It is important for the survival and successful development of minority health professions schools that this Subcommittee enact legislation for institutional aid to those medical schools which demonstrate the capacity and the ability to respond to the national need to train more minority students for careers as primary care physicians. These institutions are national priority institutions.

I know that the members of this distinguished Subcommittee are concerned about our institutions. I believe that you are wrestling honestly with problems that will have a tremendous impact on the minority groups of this nation. I suggest to you that for all your concerns, nothing should challenge you more than this.

In this presentation, I have shared with you my concerns and perspectives on Health Manpower Legislation. I have made recommendations which I feel will be of great benefit not only to the School of Medicine at Morehouse College and other minority health professions schools, but to the health status of blacks and other minorities throughout this great land. I know that this Subcommittee will go forward and lead in solving some of these problems through legislative innovation.

We stand ready to work with you in these efforts.

Thank you for this opportunity to share our views with you.

Respectfully submitted,

Louis W. Sullivan

Louis W. Sullivan, M.D.
Dean and Director
School of Medicine at
Morehouse College

TABLE I

Current and Projected Student Enrollment in the School of Medicine at Morehouse College, 1978 - 1988

Class	1978-79	1979-80	1980-81	1981-82	1982-83	1983-84	1984-85	1985-86	1986-87	1987-88	1988-89
Freshmen	24	24	32	48	64	80	96	96	96	96	96
Sophomore		24	24	32	48	64	80	96	96	96	96
Junior						48	64	80	96	96	96
Senior							48	64	80	96	96
Total	24	48	56	80	112	192	288	336	368	384	384

STATEMENT OF MEHARRY MEDICAL COLLEGE

Mr. Chairman and Members of the Committee:

My name is Ralph H. Hines; I am the Provost and Executive Vice President of Meharry Medical College, located in Nashville, Tennessee. It is a pleasure to present this testimony to you today. I am here to inform you about Meharry and its special concerns and needs, and to give our support to HR 6802, the Health Profession Training and Distribution Act of 1980.

Meharry Medical College, founded in 1876, is the nation's only privately endowed, predominently black institution of medicine and dentistry. The College has graduated 43 precent of this nation's practicing black physicians and dentists. It consists of schools of medicine, dentistry, graduate studies, and the allied health disciplines. During this decade the College has realized a dramatic enrollment increase, in keeping with the national concern about alleviating health manpower shortages, shortages which have been particularly serious in minority communities. Today Meharry has a total enrollment of 1,100 students in all programs, compared to 434 ten years ago. Slightly over half of this total is in medicine and dentistry, with over 500 preparing for the M.D. degree. Some 77 percent are black, 23 percent are non-black, consisting of white, hispanic , native american, foreign and asian american students.

Meharry throughout its history, has served as a special national and regional resource for expanding access to health sciences training and service. There are several ways in which Meharry has led the nation, ways which add further impact and significance to the essential role it plays. For example, the College leads the nation in the percentage - (76 percent) of its graduates who are working among the urban and rural poor, groups which have the highest rates of illness in our nation. Also, of all black students in the twenty-nine medical schools in the South, 37 percent are enrolled in study at Meharry.

Some 40 percent of the College's medical graduates return to the South to settle and practice, twice the number of all other minority medical graduates and nearly twice the number of all other graduate physicians. Meharry graduates are known for their commitment to primary care and more of them go into primary care settings than do the graduates from any other medical school (76 percent). Finally, for the nation as a whole, 15 percent of all medical students come from "disadvantaged" backgrounds, from families where total income is below $10,000 annually; at Meharry that figure is 49 percent, the highest in the country.

For the past five years we have seen an erosion of the number of black and other minority students who have gained access to the health sciences field. In fact there are fewer black students in the entering classes of medicine and dentistry today than there was in 1972. (Medicine 1971-72 - 7.1%; 1978-79 - 6.4% -- Dentistry 1971-72 - 5.2% 1978-79 - 4.4%). The following table illustrate the dramatic changes which have occurred during this period and points out the importance of a national commitment to assisting minority health sciences institutions.

TABLE I

BLACK ENROLLMENT IN FIRST-YEAR CLASSES IN U. S. MEDICAL SCHOOLS (1971-1978)

YEAR	NUMBER AND PERCENT OF ENROLLMENT		TOTAL FIRST YEAR ENROLLMENT
1971-72	882	7.1	12,361
1972-73	957	7.0	13,677
1973-74	1,027	7.3	14,154
1974-75	1,106	7.5	14,763
1975-76	1,036	6.8	15,295
1976-77	1,040	6.7	15,613
1977-78	1,085	6.7	16,136
1978-79	1,061	6.4	16,501

Source: Medical school admission requirements 1980-81, United States and Canada, 30th edition, Association of American Medical College, One Dupont Circle, Washington, D. C.

TABLE II
MINORITY STUDENTS IN FIRST YEAR OF DENTAL SCHOOL
ACADEMIC YEAR 1971-72 THROUGH 1978-79 1/

Academic year	Total first year students	Racial / ethnic category							Percent minority of total first-year students
		Black	American Indian	Mexican-American	Puerto Rican	Oriental (Asians)	Other minority	minority	
1971-72	4,705	245(5.2%)	4	27	13	112(2.4%)	11	412	8.8
1972-73	5,287	266(5.0%)	5	53	3	138(2.6%)	10	475	9.0
1973-74	5,389	273(5.3%)	12	64	5	141(2.6%)	34	529	9.8
1974-75	5,555	279(5.2%)	12	68	7	142(2.6%)	43	551	9.9
1975-76	5,697	298(5.2%)	22	64	11	186(3.2%)	56	637	11.2
1976-77	5,869	291(5.0%)	21	81	15	174(3.0%)	68	650	11.1
1977-78	5,890	296(5.0%)	10	2/	2/	225(3.8%)	2/	641	10.9
1978-79	6,301	280(4.4%)	16	122*		263(4.2%)		581	10.8

SOURCE: AMERICAN DENTAL ASSOCIATON, COUNCIL ON DENTAL EDUCATION. MINORITY STUDENT ENROLLMENT AND OPPORTUNIITES IN. U.S. DENTAL SCHOOLS, FOR 1971-72 AND FOR 1972-73. MINORITY REPORT: SUPPLEMENT OF ANNUAL REPORT ON DENTAL EDUCATION 1973-74, AND REPORTS FOR SUBSEQUENT ACADEMIC YEARS. CENSUS OF POPULATION PART I, U.S. SUMMARY 1970. BUREAU OF THE CENSUS POPULATON PROFILE OF THE UNITED STATES: 1978.

This record of national leadership is related to several critical problems which place Meharry in a special situation among the nation's private medical institutions. Many obstacles confront us in achieving adequate financing to maintain and improve our teaching and instructional strength. We believe that HR 680 ~~S-2375~~ addresses many of these needs in a forthright and responsive manner.

One of these problems is the result of the College's unique national mission. Meharry's Traditional purpose expresses itself as an "empathy for the disadvantaged of all origins." In keeping with this historic and unique mission the College enrolls more disadvantaged students, as mentioned above, than any other medical school in the United States. Some 86 percent of our student body requests and need financial aid to help them pay tuition and other expenses. Tuition costs stand currently at $5,000 per annum, up 60 percent from two years ago. While the College relies heavily on tuition and fees for income, raising the tuition much beyond the present level would result in only a marginal increment in operating income, and would be counter-productive to the College's special role in educating the disadvantaged. Even for those few who can pay, the gap between tuition and fees and what their education costs per year is sizeable. Thus Meharry's scholarship needs are substantial, and meeting them places significant financial burdens on the College.

Another factor which contributes to a weakened financial sitution is related to the special educational needs of our students. Many bring with them the remnants of prior educational disadvantage. Academic enrichment activities are therefore, a regular part of the College's program. These efforts require core staff as well as qualified support personnel. This means that already scarce resources have more demands made upon them than should be allowed or acceptable. As a result, for example, the number of our full-time basis sciences faculty has increased only marginally during a period when total medical school enrollment has nearly doubled.

The College's background suggests another factor which impacts upon its finances. Meharry was the creators of the Freedman's AID Society during the reconstruction era. Its early years were characterized by both struggle and minimal resource. It survived and the Flexner Report Praised Meharry as an institution "worth preserving". Since then it has resolutely carved out for itself a unique place in the network of health sciences institutions in this country. However, the years of doing "somewhat more" with "somewhat less" have meant the College's endowment base is insignificant and thus has been unable to keep pace with growth and demands in other areas. In addition, there is no direct state support which we can count on. Tennessee is prohibited by state constitutional law from providing direct financial assistance to a private or parochial institution.

A final item which as contributed to the financial situation of the College is one common to many educational institutions. I refer to the escalating costs of operations. Over the past several years fuel and energy costs have increased

850

drastically, as have building upkeep and insurance premiums, service expenses, salary and employee benefits, and material and supply expenses. At Meharry every effort is being made to reduce expenses and to cut back non-essential activities. Management techniques have been introduced to implement cost reductions wherever possible. However, increased costs remain a pressure point, and in combination with other factors, have added to the College's weakened financial situation.

Meharry has been in financial distress for many years. It has been one of several institutions for which Congress sought to provide special assistance under Section 773 of the Public Health Service Act, the Comprehensive Health Manpower Training Act of 1971 (P.L. 92-157). Under Section 773, grants were authorized to assist any school of medicine, dentistry, osteopathy, optometry, veterinary medicine, pharmacy or podiatry which could prove serious financial straits. Meharry has qualified for and received grant awards under this financial distress mechanism since its inception. This assistance has been invaluable.

However, while the financial distress program has provided Meharry certain relief in meeting its needs, a number of less than beneficial side effects have also resulted, effects which undermine and curtail our future financial stability. Many of the hoped for goals envisioned for the program under Section 773 have not been realized satisfactorily. Some of its side effects have contributed to worsening the situation, in fact, and the posture of Meharry today is such that our very survival is at issue.

I am respectfully requesting, therefore, that this Committee and other appropriate Legislative Committees of the Congress carefully consider the recommendations of the Consortium of Minority Health Professions Schools which we believe makes substantive improvements in HR 6802 and which, if adopted would be more responsive to the needs of Meharry Medical College and other predominently black health sciences institutions and adopt the provisions contain therein which would ensure the financial stability of these institutions.

We strongly urge the adoption of this Bill because it does give emphasis to areas of grave concern to us and proposes solutions to assist the real and vital areas of health manpower shortages and problems.

Its attention to scholarships and loan needs of disadvantaged students; its thrusts in increasing and redistributing family medicine professionals; and its timely support to institutions meeting national priorities are all valid and justifiable strengths which are in the national interest.

This new approach would represent an enormous improvement over the means presently available to assist Meharry and other predominently black health professional schools and would effectively eradicate most of the serious problems outlined above. It would help create the guarantees we need in overcoming many obstacles, assure our survival, and secure the financing required to maintain the College's unique educational strength in pursuit of its indispensable national mission.

I am grateful for this opportunity to speak in support of this improved approach to meeting our special needs, and urge your early and favorable consideration.

STATEMENT
Submitted to the
Subcommittee on Health and the Environment
of the
Committee on Interstate and Foreign Commerce
House of Representatives
March 21, 1980
Washington, D.C.
by
Anthony M. Rachal, Jr.
Executive Vice President
XAVIER UNIVERSITY OF LOUISIANA
New Orleans, Louisiana

Mr. Chairman, and distinguished members of the Subcommittee on Health and the Environment of the House of Representatives Interstate and Foreign Commerce Committee. We are pleased to have the opportunity to make this presentation on the need for financial assistance to a National Resource, our College of Pharmacy. We respectfully contend that it is in the national interest to assure the future of this institution.

Xavier Univeristy operates the only private College of Pharmacy in the United States with the special mission of bringing more minorities into the health professions. Xavier, then is national resource that should be preserved and strengthened. Xavier in 1977-78 accounted for 61% of the total black enrollment in the 15 private Colleges of Pharmacy in the United States (108 out of 176 students). The 72 colleges of Pharmacy produced 250 Black graduates in 1978-79. 43, or 17.2%, graduated from Xavier. It educates over 10% of all the black students enrolled in the 72 Colleges of Pharmacy across the country.

Xavier's College of Pharmacy offers a quality program: over the past two years, 100% of the graduates who applied have passed the State Board Examination. But the program is costly, especially to an institution whose resources are so sparse. Mounting deficits have threatened the College's existence. In response to this crisis, we have, in addition to making appeals to alumni and private donors, sought more outside funding through federal grants available to Health Profession Schools.

Xavier has applied for and received a grant as a Health Profession School in Financial Distress each year since the Public Health Service instituted this program in 1970. Never has there been any doubt that the institution qualifies. An abundance of documented evidence confirms that we were in financial distress at the beginning of the decade. We are in financial distress now. And, we will be in financial distress through the next decade, unless some significant help is acquired.

The kind of help Xavier has received through distress grants is precisely what was needed; but, the degree of help provided thus far has not been sufficient. Under a bare bone budget, which provided minimum support to meet accreditation standards, our audited figures for Fiscal Year 1976-77 show actual expenditures exceeded income by slightly more than $177,000. Our Financial Distress Grant for that year was $74,000. In other words, we needed two and one half times the amount funded. Last year, with your help in eliminating the 75% rule, the gap for fiscal year 1979 was narrowed considerably, but we received only half of our need. We have sought funds from non-federal sources with good results, but the dollars remain inadequate for our needs.

Over the past seven years, we have cooperated with Public Health officials in drawing up realistic and workable plans to bring the institution out of its deficit state. The plans made in the early years had to be scrapped because accreditation requirements forced us to double the number of faculty for the College since 1975. These skyrocketing personnel costs, combined with the inadequate funding of distress grants in recent years, plus the fact that the Financial Distress program was being phased out, causes us grave concern for the future.

Our institutional ills are financial -- not academic or management. We have tried to utilize all the means at our disposal to solve our financial problems. Every recommendation that has come out of our on-going dialogue with the Public Health Service has been implemented; our audits have been found acceptable and the overall quality of the program has been maintained.

At one time increasing income by increasing enrollment was a feasible option. It no longer is. Enrollment is at capacity.

Our experience with tuition increases has shown that they have barely allowed us to keep pace with inflation; rising costs have minimized our chances for reducing the deficit through this route. There will, of course, be future tuition increases, but as the only private College of Pharmacy in the nation with a predominantly black low-income student body we cannot price our services beyond the reach of our clientele. Our current tuition rate of $2,400 per year is well below the national average $3,100 for private schools of pharmacy, but the economic status of our student is proportionately far lower than that of their peers in other institutions.

Other actions taken include acquiring state financing, improving our management system, and initiating cooperative arrangements with other institutions. Public Health Service reports show how successful the management improvement effort has been.

Following a site visit by a Task Force of the Public Health Service and reported to the Congress by the Secretary of DHEW*, we were supported in our claim to be a national resource. The Task Force also reported favorably on our programs, the operation of them and our projected budgets. Actually it recommends larger expenditures.

In summary, we have taken every reasonable step we can to avoid a condition of financial distress; we have followed as best we could the recommendations of Public Health officials, who have been understanding and helpful; and yet we are projecting a deficit of $600,000 this year.

On the attached sheets we show a projected cumulative deficit of three million, one hundred thirty-five thousand dollars through 1982. This amount includes the funding necessary to continue to meet accreditation requirements and to maintain the educational program at the high level of quality which we have achieved in the past.

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*Reports from Secretary, DHEW requested by House Report No. 95-1248 and Senate Report No. 95-1119.

We hope that our past performance and our potential are weighed carefully in granting consideration and ultimate support for the proposed legislation we seek to provide the resources necessary for this unique institution's survival. The American people could not make a sounder investment.

Private Colleges of Pharmacy

(Final 3 Years Full Time Enrollment Figures from AACP for Academic Year 1977-78)

Institutions	TOTAL Students	Black Students
Samford University	321	3
University of the Pacific	423	4
University of Southern California	449	10
Mercer University	319	10
Butler University	259	1
Drake University	262	3
Northeastern University (Massachusetts)	422	0
St. Louis College	419	8
Creighton University	194	6
St. John's University	668	14
Ohio Northern University	406	2
Duquesne University	367	2
Philadelphia College	566	5
Xavier University	223	108
	5298	176

XAVIER UNIVERSITY OF LOUISIANA

COLLEGE OF PHARMACY

Summary Schedule

No.	Fiscal Year Date	Current Fund Revenues	Current Fund Expenditures	Surplus (Deficit) *	* Percent of Budget
ACTUAL					
1	76 - 77	$ 710,708	$ 963,172	$(252,464)	26.2%
2	77 - 78	891,758	1,187,030	(295,272)	24.9%
3	78 - 79	982,890	1,367,807	(384,917)	28.1%
CURRENT					
4	79 - 80	983,250	1,583,760	(600,510)	37.9%
PROJECTED					
5	80 - 81	1,078,000	1,710,360	(632,360)	37.0%
6	81 - 82	1,203,000	1,873,600	(670,600)	35.8%
7	82 - 83	1,354,000	1,995,610	(641,610)	32.2%
	TOTAL	$ 7,203,606	$ 10,681,339	$ (3,477,733)	32.6%

October 1, 1979

XAVIER UNIVERSITY OF LOUISIANA - COLLEGE OF PHARMACY

Statement of Current Fund Revenues, Expenditures & Transfers for the Seven Year Period Ending June 30

	76-77 (1)	77-78 (2)	Rate of Change %	78-79 (3)	Rate of Change %	79-80 (4)	Rate of Change %	80-81 (5)	Rate of Change %	81-82 (6)	Rate of Change %	82-83 (7)	Rate of Change %	TOTAL 7 YEARS	Ref. Nos.
CURRENT FUND REVENUES															
Tuition & Fees	439,744	512,022	16.4	540,494	5.6	608,000	12.5	675,000	11.0	775,000	14.8	825,000	6.5	4,375,220	1
Gifts	29,460	6,976	(76.2)	91,226	1207.7	30,000	(67.1)	45,000	50.0	50,000	11.1	100,000	1.0	352,662	2
Federal Capitation	71,793	91,618	27.6	79,093	(13.7)	64,000	(19.1)	45,000	(29.7)	30,000	(33.3)	25,000	16.7	406,504	3
Sponsored Programs (Direct Expenses Recovered)	144,461	253,892	75.8	245,127	(3.5)	250,000	2.0	275,000	10.0	300,000	(89.1)	350,000	16.7	1,818,480	4
State Capitation	25,250	27,250	7.9	25,250	(7.3)	28,750	13.7	35,000	21.7	45,000	28.6	50,000	11.1	236,500	5
Other Sources	- 0 -	- 0 -		1,740		2,500	43.7	3,000	20.0	3,000	0.0	4,000	33.3	14,240	6
TOTAL REVENUES	710,708	891,758	25.5	982,930	10.2	983,250	0.03	1,078,000	9.6	1,203,000	11.6	1,354,000	12.6	7,203,606	7
CURRENT FUND EXPENDITURES															
Salaries & Fringe	401,759	499,195	24.3	572,383	14.7	694,000	21.2	814,000	17.3	890,000	9.3	951,500	6.9	4,022,037	8
Student Wages	30,991	42,119	35.9	56,128	33.3	57,000	1.6	59,000	3.5	62,000	5.1	65,000	4.8	272,236	9
Travel	19,708	19,931	1.1	29,249	46.7	32,000	9.4	35,000	9.4	38,000	8.6	40,000	5.3	213,884	10
Equipment	17,293	18,980	9.8	65,547	245.3	38,000	(42.0)	40,000	5.3	45,000	12.5	50,000	11.1	274,020	11
Supplies	55,002	50,949	(7.4)	70,467	38.3	65,000	(7.8)	70,000	7.7	75,000	7.1	80,000	6.7	466,410	12
Utilities	31,491	42,658	35.5	44,980	5.4	55,000	22.3	65,000	18.2	80,000	23.1	90,000	12.5	409,129	13
Renovations	- 0 -	- 0 -		13,009		45,000	229.9	10,000	(77.8)	10,000	0.0	- 0 -	(1.0)	78,809	14
Other Expenses	37,512	61,573	64.1	18,743	(69.6)	10,000	(46.6)	15,000	50.0	15,000	0.0	15,000	0.0	172,027	15
Institutional Services	285,248	369,404	29.5	417,840	13.1	513,560	17.1	602,360	13.3	658,600	9.3	704,110	6.9	3,551,122	16
TOTAL EXPENDITURES	879,004	1,104,808	25.7	1,289,160	16.7	1,509,560	17.1	1,710,360	13.3	1,873,600	9.5	1,995,610	6.5	10,362,082	17
MANDATORY TRANSFERS															
Principal	70,000	70,000	0.0	70,000	0.0	70,000	0.0	- 0 -	(1.0)	- 0 -	0.0	- 0 -	0.0	280,000	18
Interest to Date	14,168	12,222	(13.7)	8,667	(29.1)	4,200	(51.5)	- 0 -	(1.0)	- 0 -	0.0	- 0 -	0.0	39,257	19
Total Exp. & Transfers	963,172	1,187,030	23.2	1,367,827	15.2	1,583,760	15.8	1,710,360	8.0	1,873,600	9.5	1,995,610	6.5	10,681,339	20
SURPLUS OR (DEFICIT)	(252,464)	(295,272)	17.0	(384,897)	30.4	(600,510)	56.0	(632,360)	5.3	(670,600)	6.0	(641,610)	(4.3)	(3,477,733)	21
FINANCIAL DISTRESS FUNDS	76,119	167,757		321,314		1,047,089		632,360		670,600		641,610		3,554,869	22
Adj. Surplus or (Deficit)	(176,345)	(127,515)		(63,583)		446,579		- 0 -		- 0 -		- 0 -			
Cumulative (Deficit)	(255,481)	(382,996)		(446,579)		- 0 -		- 0 -		- 0 -		- 0 -			

STATEMENT FOR THE HEALTH PROFESSIONS EDUCATION AND NURSE TRAINING AMENDMENT OF 1980 (HR 6802)

Committee on Interstate and
Foreign Commerce and
Subcommittee on Health and Environment

United States House of Representatives
Washington, D. C.
Friday, March, 21, 1980

PREPARED BY:

Florida Agricultural and Mechanical University
School of Pharmacy
Tallahassee, Florida 32307

Charles A. Walker, Ph.D. - Dean

Mr. Chairman, I, Charles A. Walker, Dean of the School of Pharmacy at Florida Agricultural and Mechanical University (FAMU), welcome the opportunity to share with you our unique role and needs as a health professions school.

Our School of Pharmacy offered its first course of instruction in the Fall of 1951. To date, we have produced more than 600 pharmacists who are located throughout the United States (Table 1). They are serving the nation in various disciplines of the profession (Table 2).

FIGURE 1

FAMU PHARMACY GRADUATES

PERCENT DISTRIBUTION BY REGION IN THE UNITED STATES

REGION	PERCENT DISTRIBUTION
Northeastern	12%
Southeastern	60%
North Central	15%
Southwestern	8%
West	5%
	100%

FIGURE 2

FAMU PHARMACY GRADUATES

TYPE OF PRACTICE BY DISCIPLINE IN THE PROFESSION

TYPE OF POSITION	PERCENT
Community Pharmacy	65%
Institutional Pharmacy	15%
Industrial Pharmacy	2%
Governmental	5%
Pharmacy Education	10%
Other Careers	1.5%
Undetermined	1.5%
	100%

A majority of FAMU Pharmacy graduates are American blacks; however, approximately 100 Cuban pharmacists have received degrees from Florida A&M. The present enrollment is 316 undergraduate students, the majority of whom can be classified as under-represented disadvantaged. Seventy-five percent are American blacks, 20% are American whites, mainly from the rural areas of North Florida, South Alabama and South Georgia where health care services are minimal, and 5% are of Spanish origin. Our present enrollment consists of 54% female.

In order to reach parity, this country needs 14,000 black pharmacists. Presently, there is one black pharmacist for each 11,000 black persons compared to one non-black pharmacist for each 1,500 non-black persons. There are 72 accredited colleges and schools of pharmacy, four of which are predominantly black. For the past five years, 1974-75 through 1978-79, a total of 34,158 baccalaureate pharmacists were produced; only 1,060 were black. The predominantly black colleges of pharmacy produced 553 American black pharmacists during the past five years or better than 50% of the total (Table 3).

While Florida A&M University and Texas Southern are predominantly black pharmacy programs located at state institutions, these schools serve as extremely important national resources for health professionals. These schools, out of tradition, attract and graduate significant numbers of minority pharmacists. During the past five years, 30% of all black pharmacists have graduated from these two institutions. The graduates are located throughout the United States and are serving as health resources persons primarily for the socially and economically disadvantaged. Inadequate support for the programs is due to several factors: (1) historically, the traditional black colleges have suffered long years of financial neglect and (2) funding has and continues to be provided through the slim and inadequate liberal arts education and general university budgets. These are but some of the reasons for needed continued and expanded federal assistance.

Florida A&M University joins the other members of the Minority Consortium in requesting institutional support as an investment in our program to allow us

TABLE 3

MINORITY BACCALAUREATE GRADUATES OF COLLEGES AND SCHOOLS OF PHARMACY

ACADEMIC YEARS 1974-75 -- 1978-79

Academic Year	Total Graduates	White Americans	%	Black Americans	%	+	Hispanics	%	Native Americans	%	Asian Ancestry	%	Others & Foreign	%
1974-75	5,739	4,919	85.71	176	3.07	107	119	2.07	8	0.14	188	3.28	329	5.73
1975-76	6,645	5,872	88.37	183	2.75	86	101	1.52	11	0.17	149	2.24	329	4.95
1976-77	7,385	6,597	89.33	218	2.95	115	97	1.31	9	0.12	138	1.87	326	4.41
1977-78	7,363	6,638	90.15	225	3.06	105	111	1.51	2	0.03	150	2.04	237	3.22
1978-79	7,026	6,298	89.64	258	3.67	140	99	1.41	15	0.21	152	2.16	204	2.90
TOTAL	34,158	30,324	88.78	1,060	3.10	553	527	1.54	45	0.13	777	2.27	1,425	4.17

+ = FIGURES FROM THE 4 PREDOMINANTLY BLACK COLLEGES.

DATA COLLECTED FROM THE AMERICAN JOURNAL OF PHARMACEUTICAL EDUCATION.

to continue on the course that we have charted. For the past two years, FAMU has produced 18% of the black baccalaureate pharmacists in the country. We have presently enrolled 40% of the black minority M.S. candidates in the pharmaceutical sciences and 50% of the black minority Doctor of Pharmacy candidates. FAMU has the only post-baccalaureate program at predominantly minority pharmacy schools. Institutional support as proposed by the Consortium would allow us to continue to (successfully) produce this desperately needed health manpower personnel. Previous institutional support in the form of capitation funds did not accomplish the goal of increasing sufficiently the number of minorities, especially American blacks in the health professions. The imbalance still exists in that only about 2% of the pharmacists today are black. Institutional support for an additional specified period of time would allow our program to meet the stringent requirements of our accreditation council, maintain and graduate our present accelerated student enrollment, effectively address our student retention problem, strengthen in general institutional capabilities and develop the clinical phase of our program as was mandated for all colleges of pharmacy.

Student assistance is extremely important for minority students to realize their goal of becoming health professionals. A majority of the students at FAMU as well as a majority of the students attending other predominantly black colleges and universities are classified in the poverty category. We endorse the Consortium Proposal relative to student assistance. We feel that these programs would be helpful in allowing most students at FAMU to successfully complete a curriculum in pharmacy.

We endorse very strongly the position of the Consortium relative to expanding the Health Careers Opportunity Program (HCOP). Our experience with this program for the past four years has been extremely important in identifying and motivating students who otherwise were not cognizant of the health programs or who had inadequate academic preparation and counseling for pursuing a health science career.

New requirements for all schools of pharmacy include clinical training, a very expensive component of the curriculum. Included in the clinical component is the need for specialized laboratories relative to Drug Monitoring, Drug Literature Information and additional faculty and staff. In conjunction with the apparent present inadequate funding, predominantly minority schools have not developed many of the facilities for this required phase of the curriculum. We totally support additional construction, funds as recommended by the Consortium.

We appreciate the opportunity to provide input and explain our needs in an effort for this program to continue its important mission of providing health care for several million people in this country.

STATEMENT
OF THE
AMERICAN ACADEMY OF DERMATOLOGY

THE AMERICAN ACADEMY OF DERMATOLOGY, WHOSE MEMBERSHIP OF 5200 REPRESENTS OVER 90% OF THE PRACTICING DERMATOLOGISTS IN THE UNITED STATES, APPRECIATES THE OPPORTUNITY TO SUBMIT ITS STATEMENT ON H.R. 6802, THE HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE AND NURSE TRAINING AMENDMENTS OF 1980.

THE AMERICAN ACADEMY OF DERMATOLOGY HAS BEEN ENGAGED IN PHYSICIAN MANPOWER NEEDS ANALYSIS SINCE 1971 AND HAS BEEN AN ACKNOWLEDGED LEADER IN THIS FIELD. AMONG OUR ACCOMPLISHMENTS ARE THE FIRST COMPREHENSIVE STUDY BY A SPECIALTY OF ITS FUTURE REQUIREMENTS FOR MANPOWER, A SUSTAINED PLACEMENT PROGRAM TO INFLUENCE THE PROBLEM OF GEOGRAPHIC MALDISTRIBUTION OF DERMATOLOGISTS SINCE 1973 WHICH, ON A VOLUNTARY BASIS, AT LOW COST, IS DEMONSTRABLY SUCCESSFUL, AND A CONTINUING ASSESSMENT OF THE MOST APPROPRIATE LEVEL OF DERMATOLOGIC MANPOWER NECESSARY TO ASSURE OPTIMUM ACCESS OF PATIENTS TO DERMATOLOGIC CARE.

ON THE BASIS OF OUR EXTENSIVE EXPERIENCE IN THE ARENA OF MANPOWER NEEDS ESTIMATES CERTAIN FACTS HAVE BECOME PATENTLY CLEAR:

1. THERE ARE NO SIMPLISTIC SOLUTIONS WHICH ARE APPROPRIATE FOR THESE COMPLEX PROBLEMS.
2. THE DATA BASE IS IMPROVING BUT IT IS STILL OFTEN INADEQUATE TO MAKE FINELY TUNED PREDICTIONS.
3. ANY PREDICTIONS ARE ENTIRELY SUBJECT TO SUBSTANTIAL MODIFICATION DEPENDING ON CHANGES IN THE HEALTH CARE DELIVERY SYSTEM, THE TYPE AND LEVEL OF THIRD PARTY REIMBURSEMENT, THE ULTIMATE LEVELS OF CO-PAYMENT AGREED UPON, FUTURE IMPROVEMENTS IN HEALTH CARE METHODOLOGY AND TECHNOLOGY, THE MIX OF SPECIALISTS, PRIMARY CARE PROVIDERS AND NEW HEALTH PERSONNEL AND A HOST OF OTHER FACTORS.
4. VOLUNTARY MODIFICATION OF BEHAVIOR THROUGH EDUCATION AND INFORMATION IS FEASIBLE AND UNDOUBTEDLY PREFERABLE TO REGULATORY INITIATIVES OR

INDUCEMENTS WHICH FAIL TO MEET THE TEST OF APPROPRIATENESS TO THE SOCIOECONOMIC OR MARKETPLACE FORCES WHICH MOLD THE BEHAVIOR OF PROFESSIONAL PEOPLE.

WE HAVE BEEN INCREASINGLY CONCERNED THAT MAJOR MODIFICATIONS IN THE NUMBER AND TYPES OF PRIMARY CARE PROVIDERS, SPECIALISTS, NEW HEALTH PRACTITIONERS AND ALLIED HEALTH PERSONNEL ARE BEING PROPOSED AND INITIATED ON THE BASIS OF WHAT WE ARE CERTAIN ARE INADEQUATE AND INAPPROPRIATE DATA WITH LITTLE ATTENTION BEING PAID TO MARKET FORCES OR PREDICTED CHANGES IN THE HEALTH CARE DELIVERY OR REIMBURSEMENT SYSTEM. WE WOULD CONTEND THAT SUCH MODIFICATIONS ARE ILL-ADVISED AND MAY PROVE TO BE DISRUPTIVE TO A HEALTH CARE SYSTEM WHICH IS STILL THE BEST AND MOST EFFICIENT IN THE WORLD.

WE NOTE WITH CONCERN THAT H.R. 6802 PROPOSES TO MAKE INSTITUTIONAL SUPPORT GRANTS CONTINGENT UPON A NATIONAL GOAL OF 30%, 35% AND 40% LEVELS OF PRIMARY CARE RESIDENCY POSITIONS FILLED AFTER DEDUCTIONS FOR TRANSFERS FOLLOWING THE FIRST POSTGRADUATE YEAR OF TRAINING FROM PRIMARY CARE POSITIONS AND AFTER DEDUCTIONS FOR FIRST YEAR SUBSPECIALTY POSITIONS IN INTERNAL MEDICINE AND PEDIATRICS. THE BEST ESTIMATES AT THIS TIME INDICATE THIS WOULD MEAN THAT APPROXIMATELY 70-75% OF ALL RESIDENCY POSITIONS WOULD BE FILLED BY FAMILY PRACTICE, INTERNAL MEDICINE AND PEDIATRIC RESIDENTS OR SUBSPECIALTY RESIDENTS IN THE LATTER TWO DISCIPLINES IN ORDER FOR INSTITUTIONS TO QUALIFY FOR SUPPORT. WE BELIEVE THAT THIS DRASTIC SHIFT WOULD BE PROBABLY UNATTAINABLE BUT, EVEN IF ATTAINABLE, IT MAY PROVE TO BE DISRUPTIVE AND NOT IN THE PUBLIC INTEREST. FURTHERMORE, THE DAMAGE CAUSED BY THIS UNPRECEDENTED SHIFT COULD BE LONG-LASTING AND RESULT IN REDUCED QUALITY OF

CARE FOR SOME YEARS TO COME FOR ALL AMERICANS.

WE WOULD CONTEND THAT THOSE WHO WOULD JUSTIFY THIS MAJOR NEW ALTERATION ON THE BASIS OF THE INSTITUTE OF MEDICINE'S 1978 REPORT ON PRIMARY CARE ARE UTILIZING A BADLY-FLAWED DOCUMENT AND ARE MISINTERPRETING THE ACTUAL RECOMMENDATIONS WHICH DID NOT PROPOSE A 70% LEVEL OF PRIMARY CARE TRAINING. WE WOULD FURTHERMORE DIRECT YOUR ATTENTION TO THE FACT THAT ALL SUGGESTED FIGURES FOR THE OPTIMUM NUMBER OF PRIMARY CARE RESIDENCY POSITIONS, EVEN THE ORIGINAL 50% FIGURE ACCEPTED BY THE COORDINATING COUNCIL ON MEDICAL EDUCATION SEVERAL YEARS AGO, ARE ENTIRELY WITHOUT ANY SCIENTIFIC JUSTIFICATION. WE FEEL IT IS UNWISE TO BASE SOMETHING AS IMPORTANT AS NATIONAL PHYSICIAN MANPOWER POLICY ON THIS UNDOCUMENTED APPROACH.

WE WOULD STRONGLY URGE THE CONGRESS TO PROCEED WITH CAUTION IN REALLOCATION OF POSITIONS FROM SPECIALTY CARE TO PRIMARY CARE UNTIL THERE IS BETTER EVIDENCE THAN IS NOW AVAILABLE THAT THIS WILL BE A TRULY COST-EFFECTIVE ALTERATION WITH NO REDUCTION IN THE QUALITY OF CARE. SUBJECTIVE APPRAISAL OF THESE ISSUES DOES NOT CONSTITUTE A RATIONAL BASIS FOR MAJOR POLICY DECISIONS WITH SUCH SEVERE DISRUPTIVE POTENTIAL.

WE WOULD FURTHERMORE URGE THE CONGRESS TO PROVIDE, THROUGH LEGISLATION, APPROPRIATE MECHANISMS WHEREBY INSTITUTIONAL COMMITMENTS TO INCREASE MEDICAL SCHOOL CLASS SIZE IN EXCHANGE FOR PAST FINANCIAL ASSISTANCE CAN BE ABROGATED IF, AS IT WOULD NOW APPEAR, IT IS DETERMINED THAT WE ARE IN THE PROCESS OF CREATING A SUBSTANTIAL NATIONAL PHYSICIAN OVERSUPPLY. A PHYSICIAN OVERSUPPLY, SUCH AS THAT NOW ENVISIONED BY MANY WHO ARE KNOWLEDGEABLE, COULD RESULT IN OVERUTILIZATION AND LEAD TO AN ESCALATION OF HEALTH CARE COSTS WITHOUT COMMENSURATE INCREASES IN THE QUALITY OF CARE.

THE AMERICAN ACADEMY OF DERMATOLOGY BELIEVES THAT CONTINUED INSTITUTIONAL SUPPORT BY THE FEDERAL GOVERNMENT IS AT THIS TIME JUSTIFIED BUT THAT TO USE SUCH SUPPORT TO ACHIEVE SUCH GOALS AS ARE LISTED WOULD BE A MISDIRECTION WHICH THE CONGRESS SHOULD AVOID. WE HOPE THE CONGRESS WILL AGREE TO DELETE THESE STIPULATIONS FROM THE INSTITUTIONAL SUPPORT GRANT SECTION OF H.R. 6802.

THANK YOU FOR THE OPPORTUNITY TO EXPRESS OUR CONCERNS.

STATEMENT OF

THE AMERICAN PSYCHIATRIC ASSOCIATION

and

THE AMERICAN ACADEMY OF CHILD PSYCHIATRY

The American Psychiatric Association (APA), a medical specialty society representing over 25,000 psychiatrists nationwide, and the American Academy of Child Psychiatry (AACP), representing 2,300 psychiatrists who have completed two years of additional training in child psychiatry, submit the following statement in regard to consideration of Federal health manpower legislation by the Subcommittee on Health and Environment of the Interstate and Foreign Commerce Committee of the U.S. House of Representatives.*

At the outset, the APA wishes to express its strong support with respect to the critical need for the development of Congressional findings which designate psychiatry as a medical shortage specialty. We believe such recognition will encourage more individuals to select psychiatry as a career and provide the needed psychological reinforcement to demonstrate both concern and reality.

During your Committee's consideration of the Nurse Training Act (H.R. 3633) in the first session of the 96th Congress,data was submitted to each member of the Interstate and Foreign Commerce Committee which articulated the reasons justifying such findings. At such time the Committee expressed the view that such designation best be considered during deliberations on renewal of the health manpower act. Accordingly, we now submit for your consideration the recommendation set forth in our March 15, 1979 statement:

> "As you know one of the President's Commission on Mental Health major recommendations was:
>
> "The Health Professions Educational Assistance Act be amended to designate psychiatry as a medical shortage specialty and require medical schools to set aside a certain proportion of their residency positions for this discipline."

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*Whenever "APA" is mentioned, such mention is intended to include the AACP.

The present statement will focus upon the scope and dimensions of America's mental illness problem and what the APA believes should be the response to those problems through Federal health manpower legislation. The statement will also provide further support for the above-cited legislative determination that psychiatry is a medical shortage specialty.

There are as many as 20 to 32 million citizens of this country identified by the President's Commission on Mental Health as in need of treatment for mental illness. We are speaking of two million individuals who have been or would be diagnosed as schizophrenic; two million who suffer from profound depressive disorders; more than one million with organic psychoses of toxic or neurologic origin and other permanent disabling mental conditions. More than 25 percent of those elderly persons diagnosed as "senile" actually have a diagnosable, and if treatable, reversible, mental disorder, and need not be forgotten, or written off by society as lost. The number of children in need of immediate psychiatric intervention is conservatively estimated by the AACP at 5 million.

Yet, the evidence with respect to the numbers of psychiatrists available to provide medical/psychiatric care for these millions of Americans, emphasizes that there is a serious shortage. For example, the FY 1980 Senate Appropriations Committee Report expressed the following concern:

> "The Committee continues to be concerned about shortages of trained psychiatrists, psychologists, psychiatric social workers and psychiatric nurses. The shortfall in personnel across the four core disciplines is most severe for psychiatry because of a rising utilization rate and a decline in the supply of both United States and foreign medical graduates in the field of psychiatry. Figures provided the Committee show that in fiscal 1980 alone there will be a shortfall of 10,000 psychiatrists and that this shortfall will increase further in the 1980s."

The FY 1981 House and Senate Labor-HEW Appropriations Subcommittee in ADAMHA hearings again expressed concern about the shortage and implored the Administration to explain how the needs of the mentally ill can be met with a static training budget. The Administration's response indicated shortage estimates for psychiatrists ranged from 10,000 to 60,000.

In the exchange between members of Congress and representatives of ADAMHA, NIMH and Secretary Harris' office regarding FY 1981 clinical manpower training funds, the response really was not whether there is a shortage, but how large it is.

A factor which had an impact on this shortage was the implementation of P.L. 94-484 which reduced the number of FMGs who could train and remain in this country. Many of these FMGs trained as psychiatrists. The APA believes that this country has the responsibility to meet its own psychiatric needs with qualified physicians and that it should not endorse or maintain policies which create a "brain drain" on foreign countries.

Further, we suggest that this nation's medical education policies should not emphasize or enhance the attractiveness of one shortage specialty, such as primary care, without analyzing the impact this emphasis will have on another shortage specialty, such as psychiatry. We endorse the support given primary care for, as you know, at least 35 percent of mental conditions are first detected by primary care physicians, but liaison psychiatry is an important concept which the pending legislation needs to develop further. Liaison psychiatry programs and activities for nonpsychiatric physicians (primary care and other medical specialties) provide education, training and assistance to such physicians by psychiatrists in the biopsychosocial aspects of medical care using the existing medical setting and patient. What is needed, however, is an equivalent commitment to recurit, train and place adequate numbers of psychiatrists to meet the varied needs and goals articulated in the President's Commission on Mental Health, its implementing task forces, and the shortage, estimated by GMENAC and acknowledged by NIMH. It will take interagency cooperation among ADAMHA, HRA, HSA, HUD, VA, DoD and others, to address this problem comprehensively.

A study of expressions of career preference among individuals who took the 1977-78 Medical College Admission Test (MCAT) was shown to reflect actual career choice. There was a 28 percent drop from 1976-77 to 1977-78 in individuals expressing a preference for psychiatry. Of the pool of applicants, only those expressing a preference in family medicine increased (from 25 percent to 35 percent in the same one-year period). The 1976 health manpower law, P.L. 94-484, was signed October 12, 1976, and the new provisions took effect October 1, 1977. This law strongly expressed Congressional recognition of the shortage of primary care physicians. Such statutory recognition had an instantaneous impact on those students who were deciding on becoming physicians. Likewise, with no concomitant expression about psychiatry, the opposite result occurred, despite data on need and utilization and projections relating to reductions in psychiatric FMGs.

While the law did create the opportunity for criteria for the designation of psychiatric manpower shortage areas under Section 332, and it was estimated that by the end of 1979, 1,200 psychiatric shortage areas would be designated pursuant to such criteria, currently there are only approximately 160 designated psychiatric shortage areas and there are only 13 psychiatrists in the National Health Service Corps.

Only late last year did the Health Resources Administration (HRA) amend the scholarship program selection criteria to give students interested in psychiatry "category one" preference (equal to that for primary care) for scholarship selection. Also noteworthy is the deplorable and inexcusable paucity of mention of the training needs of psychiatrists and the service needs for such psychiatrists in the recently released HRA publication, "Report on Health Personnel in the United States". For instance, even though there were specific designation criteria for psychiatry published in the January 10, 1978 Federal Register, the HRA publication does not either in a table or in the narrative discuss the number of psychiatric health manpower shortage areas or psychiatrists needed as of October 31, 1978, despite the fact that every other type of shortage area was displayed in the table. We note from this report that as many as one-eighth of our population resides in medically underserved areas. Moreover, the report further indicates that increasing emphasis should be placed on the needs of a population which is growing older and fraught with increasing numbers of chronic conditions. This is a population with significantly greater mental health needs. We note that the report does not raise similar concerns with respect to the mental health problems confronting our nation's population, including children and adolescents.

Congressional deliberations on the renewal of the Nurse Training Act, resulted in the law being amended to delete the three-year maximum deferment a physician could receive before he or she would be required to perform obligated service in the National Health Service Corps or Indian Health Service. Since psychiatric residencies are at least four years in length, the three-year limit clearly discriminated against psychiatric residents--not to mention psychiatric needs of the NHSC, PHS and IHS. The APA is gratified that this provision will be retained and recommends that it be authorized for other programs such as the Health Education Assistance Loan (HEAL) program.

Also, we would recommend that medical students who are preparing to become primary care physicians should receive substantial training in the biopsychosocial aspects of patient care. They then would have sufficient ability to diagnose, treat or refer, when appropriate, for mental illness. In 1976, it was estimated that 43.6 percent of persons diagnosed as having a mental disorder are treated in the general medical sector. There is a demonstrated need, therefore, for strong liaison psychiatry education in medical schools and in general residency training programs to ensure that primary care physicians will have the most appropriate tools to recognize, treate, or refer, when appropriate, those patients with mental disorders which are masked by or accompanied with physical symptoms. We would encourage the statutory inclusion of biopsychosocial aspects of medical patient care in all primary care training sections.

Further, Section 788(d) of current law contains authority to fund health manpower projects and programs such as "cooperative human behavior and psychiatry in medical and dental education and practice" (Section 788(d)(4)) and "training in the diagnosis, treatment and prevention of the diseases and related medical and behavioral problems of the aged" (Section 788(d)(21)). These programs, because of the potential they offer to address the joint presentation of physical and mental illness, should be retained. We have already discussed the essential nature of liaison psychiatry. With reference to the aged, the President's Commission on Mental Health, among other entities, has cited the cost-effectiveness of providing mental illness coverage for the aged. Therefore, training in geriatric psychiatry also would be cost effective.

With respect to provisions regarding reimbursement policies, the APA is supportive of Title V of H.R. 6802 which would revise Medicare and Medicaid reimbursement policies relating to primary care residency programs. However, we would recommend that such Title should be amended to include psychiatric residency programs and psychiatric outpatient/ambulatory care facilities, particularly because psychiatry is not a technology-oriented specialty, but a time-based specialty and has increasingly emphasized ambulatory care, prevention, and early intervention. We would welcome the opportunity to provide you with any additional information that you may require to support our suggested amendment to revise reimbursement policies for psychiatric residency programs.

Other APA specific amendments to H.R. 6800 and H.R. 6802 we submit for your consideration follow.

Additional Recommendations for H.R. 6800 & H.R. 6802

The APA supports the modifications H.R. 6802 makes to the National Health Service Corps Program and has specific additional recommendations:

(1) Subsection (g) of Section 333 (page 7 of H.R. 6802) should be amended further at lines 10 and 16 to include "and psychiatric services" after "primary health care" so that improvements in the assignment of members of the Corps to health manpower shortage areas can address the medical specialty of psychiatry for which there currently are shortage area designation criteria and service delivery needs.

(2) The number of awards to certain specialties/disiplines which data indicate are in particular shortage receive an increased percentage of scholarships until the shortage is in closer relationship to needs for other specialties/disiplines.

(3) The NHSC should become more active and proactive in informing communities of apparent underservice and offer designation and corps site development and technical assistance to them. We therefore endorse Section

337 of H.R. 6802, but would recommend report language which would emphasize the primary care and psychiatric service needs of underserved populations.

(4) The NHSC should designate all health manpower shortage areas as soon as possible and award scholarships to the appropriate specialties/disciplines in proportion to the future need for such specialties/disciplines unless the Secretary has clear and convincing evidence that such shortage can be alleviated by some other specific Federal, state, local or marketplace mechanisism(s).

(5) That Section 332(d), relating to designation of health manpower shortage areas be amended by adding at the end thereof the following:

(a) On page 5 of H.R. 6802, insert: "Priority for designation or assignment will be given to specialties/disciplines for which shortages have been determined by the Congress or the Secretary. Recruitment and assignment shall be made in relation to the future needs of such specialties/disciplines, as determined by the Secretary, unless the Secretary has clear and convincing evidence that such shortage can be alleviated by some other Federal, State, local or marketplace mechanisms. Assignment of such individuals from specialties/disciplines with such characteristics are to be made at a higher rate than the eventual need for such specialty/discipline until the shortage for such specialty/discipline is in closer relationship to the needs for other specialties/disciplines".

(6) The APA believes the 81% set aside for medical and osteopathic students has worked well and does not believe its elimination as proposed to be appropriate.

(7) The APA believes that the authorization levels for the NHSC Scholarship Program are inadequate and do not incorporate inflation or nominal growth factors.

The APA is pleased by H.R. 6802's amendments for the Health Education Assistance Loan (HEAL) program, but recommends that the three year program deferral provisions be extended appropriately and not continue to discriminate against individuals seeking to become general or child psychiatrists, four and five year residency programs. In addition to the aforementioned recent data on general psychiatrists, recent data indicate that there is a severe shortage of child psychiatrists. The present production of 200 child psychiatrists yearly is barely adequate to maintain the current force of 3,000 child psychiatrists, and does not address any of the problems of shortage, which GMENAC is expected to project at 30,000.

We therefore would recommend that Section 731(a)(2)(C) of H.R. 6802 make provisions for residencies extending beyond three years which train individuals in specialties and subspecialties determined by the Secretary to be in short supply. The APA also believes that an NHSC and Armed Forces Scholarship recipient should not be excluded from obtaining HEAL program funds, as proposed in S. 2375, because there may be circumstances which would make these additional funds essential for a student to continue to pursue a health professions education.

With regard to the First Year Scholarship Program for Students of Exceptional Financial Need (EFN), we endorse the change in the amount of the scholarship proposed by S.2375. We would hope that more students would be able to benefit from the program. Further, we would endorse the expansion of this program to a two-year program, and would also like to see the current definition of EFN revised so that a larger number of "needy" students could be included. We further urge that awards be made to such students who demonstrate interest in or commitment to complete programs in specialties or disciplines with the greatest shortage and/or maldistributions problems, and that awards not necessarily be made to all schools, consistent with the amendment in H.R. 6802.

The APA supports the continuation of the Health Professions Student Loan Program in view of its success and acceptance by both students and their institutions. We believe that Section 741(f)(1)(B) should be amended to allow all educational debts, evidenced by written agreements, to be eligible for repayment. This recommendation would require the phrase "entered into before October 12, 1976"to be deleted. This change would create larger incentives for physicians to agree to practice in shortages areas.

With respect to institutional support, the APA believes that any concept which emerges from the Congress must respond to the need to have a diversity of physicians who, by specialty and in the aggregate, can deliver high quality medical care to the population consistent with identified needs and accordingly recommend that the institutional support sections (Sections 770, 771 and 772) provide mechanisms to enhance the training of medical students who ultimately will choose a career in psychiatry and other shortage specialties. Further, these Sections should include provisions that all students (particularly those in primary care) receive substantial instruction in the biopsychosocial aspects of patient care, including prevention.

We recommend that Section 787, "Educational Assistance to Individuals From Disadvantaged Backgrounds," (and similarly in S. 2144 in Section 755), be modified to articulate the need, whenever possible, to identify, recruit and select individuals from underrepresented minority groups or disadvantaged backgrounds to become physician specialists in shortage specialties such as primary care and psychiatry.

With reference to the various Special Projects proposals, the APA encourages the modification of all appropriate authorities to ensure that emphasis be given to projects which could support and enhance the education and training of psychiatrists and other shortage specialists so that ultimately the services of these physicians could be delivered consistent with the health care needs of the population. For example, psychiatry curricula should be enhanced at medical and osteopathic schools in order to increase the likelihood that more students will choose a career in the shortage specialties of general and child psychiatry, as well as be more skilled, knowedgeable, in the biopsychosocial aspects of patient care.

The Area Health Education Centers (AHEC) Program has been and should continue to be a useful initiative. We are pleased to see this activity continued in H.R. 6802, with the requirement that there be active participation of individuals associated with departments of psychiatry. This incorporation is vital to ensure adequate exposure of medical students to biopsychosocial aspects of patient care so that they will be trained to diagnose, treat when appropriate, and refer when indicated, patients with mental disorders. We note, however, the requirement in Section 781(d)(2)(B) that each AHEC "assess the health manpower needs of the area served by the center (in coordination with the activities of the local health systems agency or agencies relating to such health manpower needs of the area) and assist in the planning and development of training to meet such needs."

However, this provision does not contain authority which would allow for the support of the provision for conduct of medical residency training programs at such AHEC in specialties other than family medicine, general internal medicine or general pediatrics, if health manpower needs were determined to exist in specialties other than those just noted.

Because of the ambulatory nature of psychiatric residency training, the documented shortage of psychiatrists, and the existence of psychiatric shortage areas and designation criteria, it is very likely that an AHEC would determine that, in accordance with Section 781(d)(2)(B), the area served by the AHEC would be in need of psychiatrists. There is, however, no comparable mechanism for the training of medical specialists other than those enumerated in Section 781(d)(2)(C) to "assist in the planning and development of training programs to meet the needs" which could be determined in Section 781(d)(2)(B).

Therefore, in order to provide the flexibility for an AHEC to address particular and specific health manpower training needs envisioned by Section 781(d)(2)(B), we recommend that such Section 781(d)(2)(B) be amended by inserting: "and, in accordance with such assessment, provide for or conduct a medical residency training program in which no fewer than six individuals are enrolled in first-year positions in such program" after "needs".

With regard to Section 794C relating to preventive or community medicine residencies, the APA believes that further emphasis needs to be placed on preventive aspects of mental illness and that the incorporation of psychiatric aspects of prevention is an integral part of any such residency program.

In order to ensure that prevention of mental illness is considered (a key need identified by the President's Commission on Mental Health), we recommend that parenthetical references to psychiatry be included in Section 794C as follows: (1) on page 39 at line 21, insert "(including psychiatry)" after "other clinical specialties;" (2) on page 40 at line 17, insert "(including course content in psychiatry)" after "preventive or community medicine;" and (3) on page 41 at line 21, insert "(including psychiatry)" after "other relevant specialties."

In addition, we endorse amendments which would support approved residency training programs that prepare residents for teaching medical students and other hospital staff in techniques of teaching, supervision, consultation, career development, and evaluation methods suited to the clinical setting. Further, the APA would encourage the inclusion of "biopsychosocial aspects of patient care" in medical school teaching programs because of the frequently inextricable nature of physical and mental illness.

Studies have demonstrated that the quality of medical student teaching is one of the factors related to the percentage of students entering psychiatry, and that higher quality programs have a sufficient well-rounded faculty, varied teaching methods, and a high degree of commitment to students. It follows that to recruit more potential psychiatrists we must conduct good teaching at medical schools, with a high degree of commitment on the part of the faculty. Teaching at the residency level must also involve both instruction in administration and exposure to exciting administrative experiences, teaching in "how to teach," and learning how to work with primary care physicians.

The programs proposed for physician residents to be exposed to the social and behavioral sciences should include a requirement, however, that physician residents (particularly those in primary care) receive training in the biopsychosocial aspects of direct patient care in inpatient and outpatient health care settings.

Our concern and comment is founded on the need for physicians to be able to diagnose, treat where appropriate, and refer when indicated, patients with mental disorders which may present themselves or be perceived as having a physical etiology. By not specifically understanding and recognizing the varied aspects of mental dysfunction, and the psychological and somatic interrelationships in physical symptomatology, the physician resident may not gain the total knowledge needed to assist patients who come to a general physician for treatment. This is particularly true for primary care physicians, who, according to a 1976 study, treated 43.6% of mental disorders presented to all physicians.

The APA supports the proposal to amend Section 212(j)(1)(D) of the Immigration and Nationality Act which would allow FMGs who have passed the Visa Qualifying Exam (VQE) to come to this country and remain for the period of time required to establish eligibility to take specialty examinations. Current law, which allows FMGs who have passed the VQE to come to the U.S. for two years to pursue medical education and to remain for an additional year if the visitor's home government approves, does not provide such FMG resident physicians adequate time to meet eligibility requirements of most medical specialty certifying boards, requirements which may be assumed to reflect the necessary period of training for a designated specialty. We believe that the proposal in H.R. 6802 to amend Section 212(j)(1)(D) is a reasonable approach which would allow an alien physician to complete residency training. An alien graduate medical education student currently is required to meet the VQE and language requirements, thus assuring his or her competence.

The APA shares the concern that by extending the "substantial disruption waiver" provision, institutions will not be encouraged or forced to address what is predominantly an educational quality issue. We do not wish to discount the service needs of populations served by residency programs which have become dependent on FMGs. Considerable thought should be given to alternative approaches which would improve these programs so that they would be attractive to U.S. medical graduates and so the populations served can receive quality medical care from U.S. medical school graduates or qualified foreign medical graduates.

The APA supports the statutory designation of hospitals with more than 25% FMG residents as health manpower shortage areas as defined in Section 332 of the PHS Act. While most beneficial to psychiatric training, we oppose the proposal allowing for the creditability of service obligation for the period

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of graduate medical education received at hospitals with a significant dependence on FMGs. The NHSC program's intent has always been to provide fully qualified physicians to deliver medical care to underserved areas and populations. In fact, the Corps continues to emphasize the placement of physicians who are board-eligible or board-certified. By adopting this creditability provision, while self-serving for psychiatry as a medical specialty, we are concerned that the purpose of the Corps would be compromised and the medical needs of the patients in the service areas would be "short-changed."

The APA has continued to support the activities of the Graduate Medical Education National Advisory Committee (GMENAC) since it was established administratively by the Secretary of HEW. We believe that data and analyses must be assimilated and critiqued by a body such as GMENAC in order to assure that geographic and specialty maldistribution issues are dealt with consistently and in an unbiased manner.

We are gratified with the accomplishments of GMENAC to date and believe its continued existence is essential. We therefore support Title IV of H.R. 6802 which would establish GMENAC statutorily, with defined functions.

We appreciate the opportunity of submitting this statement for your consideration and welcome the opportunity of working with the Committee to ensure that Federal health manpower legislation responds to our citizens who are in need of treatment for mental illness.

ICA
INTERNATIONAL CHIROPRACTORS ASSOCIATION
EXECUTIVE OFFICES

TESTIMONY OF THE
INTERNATIONAL CHIROPRACTORS ASSOCIATION
ON
HEARINGS FOR THE RENEWAL OF HEALTH MANPOWER LEGISLATION

INTRODUCTION

The International Chiropractors Association is pleased to present testimony on the renewal of health manpower legislation.

As the Subcommittee members are aware, Section 903 of the Health Profession Educational Assistance Act of 1976 provided that a study concerning the chiropractic profession be performed. This represents the first federally funded study ever done on the chiropractic profession. Specifically, the report covers the cost of education, the demand for services, the supply of chiropractors and, the types and cost of services provided by chiropractors. It is our understanding that the Department of Health, Education and Welfare will soon provide the Committee with this report.

In this statement, we are submitting additional information concerning the chiropractic profession which may be helpful to the Subcommittee. We also address the need for federal funding under health manpower programs to chiropractic students and colleges.

PART I

BACKGROUND INFORMATION ON CHIROPRACTIC

Chiropractic is the second largest primary health care service in the United States. In their order of size, and based on the number of practitioners and public utilization, the three largest branches of the healing arts are allopathic care or medicine, chiropractic and osteopathy.

All fifty states plus the District of Columbia, Puerto Rico and the Virgin Islands license and officially recognize chiropractic as a health profession. All fifty states authorize chiropractic services as part of their workmen's compenstaion program. Virtually all major commerical health and accident policies provide for chiropractic services. Major industrial unions, such as General Motors, have included chiropractic in health plans for employees and their dependents. In addition, substantial numbers of major international, and national and local unions include chiropractic in their health and welfare plans.

Chiropractic services are recognized and authorized by the federal government under Medicare, Medicaid, vocational rehabilitation programs, and the Internal Revenue Code (as a medical deduction). In addition, legislation to amend and improve current coverage of chiropractic services under Medicare has recently been the subject of favorable committee action by both the House and Senate. This measure also shares broad bipartisan support from Congress.

Sepcifically for federal employees, chiropractic services are provided under:

(1) federal employee health programs;

(2) in federal employee workmen's compensation; and,

(3) in leave approvals for civil service excuse of illness.

Federal funding of chiropractic has been provided under appropriation measures sent to the Department of Health, Education and Welfare (see page 4) and, for the statistical survey of the chiropractic profession under the last health manpower act.

The United States Office of Education officially recognizes the Council on Chiropractic Education (CCE) as an accrediting agency for chiropractic educational institutions. This autonomous national organization oversees the quality of education at the chiropractic institutions. Within the CCE is the Commission on Accreditation, which is responsible for the accredition process. This group is composed of members representing the state licensing boards, the member institutions, sponsoring national associations and non-chiropractic members representing the general public.

Currently, there are about 23,00 Doctors of Chiropractic providing chiropractic services to the public on a full-- or part--time basis. Within the next five years between 10,000 and 13,000 new Doctors of Chiropractic (D.C. s) will enter the labor force. Therefore, within the next five years the number of chiropractors practicing in this country will increase some 40 percent.

The national ratio of chiropractors to the population is 10.1 per 100,000. However, these chiropractors are not evenly distributed across the United States. The variation from state to state is significant, ranging from 1.8 per 100,000 in Virginia to 23.0 per 100,000 Iowa, and 25 percent of chiropractors are practicing in just five states.

The chiropractic profession, however, deploys most of its manpower to the nation's smallest and often most neediest communities

Slightly more than 40 percent of the D.C.'s practice in areas with fewer than 25,000 persons. A clear majority, or approximately 70 percent practice in areas with fewer than 100,000 persons.

The typical parcticing chriopractor is a white male, and approximately forty-five years of age. Less than 1 percent are either Black, Hispanic, American Indian or Asian. Only 3.2 percent are female. Therefore, in addition to the tremendous geographic and demographic maldistribution, the profession suffers a severe ethnic, race, and sex underrepresentation.

CONTRIBUTIONS MADE BY CHIROPRACTIC TO THE HEALTH NEEDS OF AMERICANS

It has been estimated that Doctors of Chiropractic had 122.5 million patients visits in 1979. This is based on survey data estimating that 6.8 million individuals went to a D.C. in 1979, and returned 17 more times for additional care during the year. However, this may be a conservative estimate given that 7.5 million individuals saw a D.C. in 1974 (1974 Health Interview Survey National Center for Health Statistics). Over $1.3 billion were generated in practice revenues in 1978 by D.C. s.

These figures show that practicing D.C. s exert a considerable influence on this nation's health needs. Because D.C. s offer a wide range of services, such as physical exams, spinal adjustments, certain x-rays, and routine laboratory services, they are valuable and important in the health care delivery system. Often as primary health care providers in rural or remote areas D.C.'s are relied on by many Americans for physical examination and spinal care or, referral to other health care providers.

STUDIES SHOW CHIROPRACTIC CARE EFFECTIVE

For 1978, the National Safety Council estimated that accidents and occupational illnesses alone cost the United States at least $84 billion. And, an estimated 10 million man-hours, or 10 percent of all lost-time injuries were the result of back injuries. This fact is relevant since results from several industrial back injury studies performed by independent groups, two by medical doctors, show that spinal manipulative therapy performed by chiropractors can be very effective in relieving musculo-skeletal symptoms. These studies (Appendix) indicate that cases handled by a chiropractor result in significantly less "time lost" by the injured party and, that chiropractic treatment results in lower medical expenses.

Considering the direct relation between the loss of productivity and the health and safety of the American work force, chiropractic care makes a tremendously important contribution not only to the health care needs of the industrial work force, but to the nation as a whole.

Back injuries are suffered by not only the industrial worker but by all Americans--from the housewife who lifts a heavy basket of clothes, to the office worker who turns the wrong way, to the weekend gardener mowing the lawn, or to any number of individuals in commonplace situations. Therefore the role of chiropractic in the health care delivery system is vitally important to the health needs of all Americans.

CHIROPACTIC RESEARCH

Although the profession has engaged in some research activities on its own, recent Federal funding has been a source of revenue and encouragement. As part of the Senate Report on the FY 1974 Appropriations for the National Institute of Neurological Diseases and Stroke (NINDS) of the National Institute of Health (NIH), the

Senate Appropriations Labor- HEW Subcommittee said "... this would be an opportune time for an 'independent, unbiased' study of the fundamentals of the chiropractic profession." Appropriation measures passed that year alloted some $2 million for chiropractic research.

In pursuit of that direction, the National Institute of Neurological and Communicational Disorders and Stoke, convened at the National Institute of Health a "Workshop on the Research Status of Spinal Manipulative Therapy" on February 2-4, 1975. This workshop focused directly on the evaluation of research results and clinical investigative experience. Participants included 58 scientists and clinicians of national and international stature including 16 Doctors of Chiropractic (D.C. s), 24 Doctors of Medicine (M.D. s), 7 Doctors of Osteopathic Medicine (D.O. s), and 11 basic scientists (mostly Ph.D. s). A second workshop was also held on October 23-27, 1977 at the Kellogg Center for Continuing Education, Michigan State University in East Lansing Michigan, and dealt with "Neurological Mechanisms in Manipulative Therapy." These workshops represent the beginnings of an interprofessional dialogue among chiropractors, physicians and biological scientists on the "neutral" and commonly-shared issues of science and research.

One observation of the NINDS workshop was that "specific conclusions cannot be derived from the scientific literature for or against either the efficacy of spinal manipulation therapy or the pathophysiological foundations from which it is derived. Chiropractors, osteopathic physicians and medical manipulative specialists and their patients all claim spinal manipulation provides relief from pain, particularly back pain, and sometimes cure." The report also noted that "some medical physicians, particularly those not trained in manipulative techniques, claim it does not provide relief, does not cure, and may be dangerous, particularly if used by non-physicians. The available data does not clarify either view " (our emphasis).

The report concludes that the "efficacy of spinal manipulative therapy is based on a body of clinical experience in the 'hands' of specialized clinicians." But, that there is little scientific data of significance from which to evaluate this clinical approach to health. The workshop suggested the promotion of fundamental and clinical research so that "answers to the questions of clinical indications and therapeutic efficacy of manipulative therapy can be approached more meaningfully." And, it did point out that "established and prestigious medical and osteopathic physicians and chiropractors provided testimonial evidence in support of the efficacy and safety of manipulative therapy.

Since 1969, basic research on the biomechanics of the spine has been conducted by Chung Ha Suh, Ph.D. at the University of Colorado. The goal of Dr. Suh's research is to learn precisely what happens - biomechanically, physically, neurologically, and chemically - when a spinal adjustment is made. One of the results of this research was the development of the first three dimensional computer model of the spine. By transfering mathematical equations relating to the spine and its articulations, into the computer, a "graphics model" has been refined to the point where it is possible to see a spine in motion when the mathematical equivalent of various physical forces are programmed into the computer. One of the goals of the project is to give practicing chiropractors the means to see exactly how a patient will be affected by an adjustment before the chiropractor actually performs it. It will help practicing chiropractors detect a subluxation more precisely and remove them more efficiently.

This program has been funded by our association and by a $238,000 grant from NHI and an application for additional funds is now pending before the National Institute of Neurological and Communicative Disorder and Stroke.

Incidentally, members of the automobile industry have purchased this three dimensional computer model of the spine for the possibility of performing less costly as well as more precise information gathering tests in automobile safety crash simulation. This is but one the many benefits which basic fundamental research can provide to the scientific community.

Continued federal interest in basic chiropractic research can be seen in Senate Appropriations Report, #96-247 to accompany H.R. 4389, a bill making appropriations to the Department of Labor and the Department of Health, Education and Welfare for the fiscal year ending on September 30, 1980. The Committee report encouraged HEW "to continue research on chiropractic services, especially the biomechanics of the spine, to scientifically evaluate the chiropractic adjustment."

As a complement to these programs and as an example of our continued interest in and support for research, ICA this year established the Institute for Chiropractic Research (ICR). The purpose of ICR is to train chiropractors to conduct clinical research in a accordance with established scientific methodology. The course will set out to train the chiropractor in proper scientific methodology, mathematics for computer, computer-aided x-rays analysis, biomechanics and writing research grant proposals. Chiropractic research is at the point of what can be described as "the tip of the iceberg." With further research, contributions which chiropratic can made to the health of Americans will only increase.

RECENT REPORT ON CHIROPRACTIC

We would be negligent if we did not bring to the Committee's attention a report commissioned by the New Zealand Government entitled, "Chiropractic in New Zealand: Report of the Commission of Inquiry". This report represents the most definitive investigation and evaluation of chiropractic in its 85 year history. looks at the profession worldwide.

For your convenience we provide a short summary and analysis of the report as it appeared in one of our publications.

> "For decades the chiropractic profession has been battling the label "unscientific cult." Now, with the overwhelming assistance of the New Zealand government, chiropractic has solid documented evidence that "modern chiropractic is a soundly-based and valuable branch of health care in a specialized area neglected by the medical profession . . . worthy of public confidence and support."

So concludes a study conducted by the New Zealand Commission of Inquiry, originally set up to determine if chiropractic services should be covered under New Zealand health and accident compensation benefits. The study, completed October 5, 1979, is guaranteed to revolutionize the status of chiropractic worldwide. What was originally thought to be a "relatively simple inquiry . . . lasting no longer than a month or two" became a nearly two-year investigation which is "the most comprehensive and detailed independent examination of chiropractic ever undertaken in any country."

Realizing the "need for solid facts and concrete evidence," in light of chiropractic's controversial history, the commission decided to conduct the inquiry through public hearings. None of the members of the commission - a scientist, chemistry professor, headmistress, and their legal counsel - had had any previous experience with chiropractic treatment. In their own words, "We had no clear idea of what might emerge . . . If we had any general impression of chiropractic it was probably that shared by many in the community: that chiropractic was an unscientific cult, not to be compared with orthodox medical or paramedical services."

After compiling 377 pages of testimony, factual evidence, and recommendations on every aspect of chiropractic worldwide, the commission concluded that their preconception of the profession was totally incorrect.

Though the original purpose of the inquiry was confined to chiropractic in New Zealand, members of the commission focused a great deal of attention on the profession in North America. Since many New Zealand chiropractors are educated outside New Zealand, the commission felt it was necessary to broaden their investigations to include Austrailia, the United Kingdom, Canada, and the United States.

The final report of the Commission is divided into six parts: 1) Introductory (to the proceedings) 2) The Essence of Chiropractic 3) Evidence Against Chiropractic 4) The Evidence in Favor of Chiropractic 5) Science and Education and 6) Chiropractic and the General Health Team.

The report also covers chiropractic education, devoting a section to the history and controversy of CCE, and further investigates the medical/chiropractic animosity, recommending that, "Chiropractors should, in the public interest, be accepted as partners in the general health care team." Finally, the study concludes with an outline of recommended benefits for chiropractic treatment.

For the first time, a study commissioned and carried out by non-chiropractors has affirmed, with evidence in hand, that "modern chiropractic is not an unscientific cult." Each area of chiropractic discussed in the study has been treated fairly and comprehensively with testimony from experts and pertinent witnesses and summaries by the commission. The impartiality and breadth of this inquiry is indisputable and recommends it as the most significant and responsible documentation of chiropractic ever produced.

Following is a summary of the Commission's principal findings, reprinted from the study's introductory section:

- Modern chiropractic is far from being an "unscientific cult."
- Chiropractic is a branch of the healing arts specializing in the correction by spinal manual therapy of what chiropractors identify as biomechanical disorders of the spinal column. They carry out spinal diagnosis and therapy at a sophisticated and refined level.
- Chiropractors are the only health practitioners who are necessarily equipped by their education and training to carry out spinal manual therapy.
- General medical practitioners and physiotherapists have no adequate training in spinal manual therapy, though a few have acquired skill in it subsequent to graduation.
- Spinal manual therapy in the hands of a registered chiropractor is safe.
- The education and training of a registered chiropractor are sufficient to enable him to determine whether there are contra-indications to spinal manual therapy in a particular case, and whether the patient should have medical care instead of or as well as chiropractic care.
- Spinal manual therapy can be effective in relieving musculo-skeletal symptoms such as back pain, and other symptoms known to respond to such therapy, such as a migraine.
- In a limited number of cases where there are organic and/or visceral symptoms, chiropractic treatment may provide relief, but this is unpredictable, and in such cases the patient should be under concurrent medical care if that is practicable.
- Although the precise nature of the biomechanical dysfunction which chiropractors claim to treat has not yet been demonstrated scientifically, and although the precise reasons why spinal manual therapy provides relief have not yet been scientifically ex-

plained, chiropractors have reasonable grounds based on clinical evidence for their belief that symptoms of the kind described above can respond beneficially to spinal manual therapy.

- Chiropractors should, in the public interest, be accepted as partners in the general health care system. No other health professional is as well qualified by his general training to carry out a diagnosis for spinal mechanical dysfunction or to perform spinal manual therapy.
- The responsibility for spinal manual therapy training, because of its specialized nature, should lie with the chiropractic profession. Part-time or vacation courses in spinal manual therapy for other health professionals should not be encouraged.
- The education provided by the International College of Chiropractic at the Preston Institute in Victoria is of a high standard.
- Bursaries should be made available to New Zealand students who wish to undertake a course leading to the B.App.Sc. (Chiropractic) degree at Preston Institute.

Again we emphasize that this is a summary of the report. We would be happy to provide full copies of this report to the Committee and its staff.

It is interesting to note that the Commission did recommend that funds be provided for chiropractic education.

CHIROPRACTIC EDUCATION

A Doctor of Chiropractic, as a member of the healing arts, is concerned with the health needs of the public. The chiropractor gives particular attention to the relationship between the spinal column and the nervous system and their role in the restoration and maintenance of health. The chiropractor is educated in the basic and clinical sciences, as well as in related health subjects. His professional education prepares the doctor of chiropractic as a primary health provider. As a portal of entry to the health delivery system, the chiropractor is well trained in diagnosis and spinal analysis, in caring for the human body in health and disease and, to consult with or refer to other health care providers when the form of treatment lies outside their specialty.

EDUCATIONAL REQUIREMENTS

The admission of students to a chiropractic institution is in the hands of an admissions officer who is a member of the Committee on Admissions of the CCE. Documentary evidence of a candidate's preliminary education is obtained directly from the undergraduate college which the candidate attended. All transcripts, and records of the candidate are kept on file at the chiropractic institution.

All candidates must furnish proof of having acquired at least two years (or 60 acceptable semester hours) leading to a baccalaureate degree in the arts and sciences, including laboratory courses in biology and chemistry.

The average length of study for students seeking a D.C. degree at a chiropractic college is three and a half calendar years (four academic years). Therefore the minimum requirements for a student to earn his D.C. degree is six academic years of training (i.e. two years of an undergraduate college and four years at a chiropractic college.) However, many in the current crop of today's chiropractic students have either a B.A. or B.S. degree and others have M.A. or M.S. before entering chiropractic college.

ACCREDITATION OF CHIROPRACTIC COLLEGES

As a national agency within the United States that accredits chiropractic colleges, the Council on Chiropractic Education is provided recognition by:

(1) The United States Office of Education's Division of Eligibility and Agency Evaluation;

(2) The Council on Postsecondary Accreditation (COPA) This is a national autonomous body that certifies anc accredits the accrediting agencies in the United States, which in turn provides the status for our colleges and universities; and,

(3) The state licensing boards of some 40 states which enhance CCE standards as the minimum that they require of applicants who seek licensure in their states.

The CCE concerns itself with the formulation of education, promotion of higher educational endeavors, and general improvement in college facilities, students and faculty. Thus, the purpose of the CCE can be briefly stated as follows:

(1) advocating high standards of quality in chiropractic

education;

(2) establishing criteria of institutional excellence for educating doctors of chiropractic and,

(3) inspecting and accrediting colleges through its Commission on Accreditation.

The Commission of Accreditation monitors the quality of education offered by the chiropractic institution. Institutions are evaluated by a highly specialized team of educational experts. Standards have been developed over the years and represent the minimum requirements an institution must meet to acquire status. These standards cover every aspect of an institution's operation and include: objectives, administration, finance, scholastic regulations, faculty, library and physical plant, research and continuing education. CCE's standards are intended as qualitative guidelines for chiropractic institutions.

Currently, seven out of the 16 U.S. chiropractic colleges are fully accredited by the CCE. An additional four institutions are "recognized candidates for accreditation." A recognized candidate for accreditation status indicates that an institution has given evidence of sound planning, has the resources to implement these plans and has an intent to work toward accreditation. Accredited status indicates compliance with all essential standards of the CCE. As such, 11 out of the 16 chiropractic colleges in the United States have status with the CCE. Four other chiropractic colleges are taking the initial necessary steps to attain status with the CCE, and are affiliated members.

CURRICULUM

The curriculum at a chiropractic college is set to provide the student with a thorough understanding of the structure and function of the human organism in health and disease. This well balanced presentation gives the student an understanding of the essential features of the life processess: digestion, excretion, physical and mental growth, nutrition, metabolism, the nervous system the significance of developmental defects, behavior and other elements which are fundamental of the understanding of pathological conditions. This understanding of structure and function makes it possible of students to identify deviations from the norm and provide the essential facts required later for diagnostic screening, chiropractic care when indicated or referral to other health care providers.

Course offerings at CCE approved colleges include the following disciplines: human anatomy, biochemistry, physiology, microbiology, pathology, public health, physical, clinical and laboratory diagnosis, gynecology, obstetrics, pediatrics, geriatirics, dermatology, psychology, dietetics, orthopedics, physical therapy, first aid and emergency procedures, spinal analysis, principles and practice of chiropractic, adjustive technique and other appropriate subjects.

CLINICAL EDUCATION FOR D.C. STUDENTS

Clinical experience is the major feature in the educational preparation of a D.C. student. Each college operates a general teaching clinic in which externs gain experience with patients in the various aspects of chiropractic practice and treatment methods.

These clinical facilities operate so that they may:

(1) provide a student with quality experience in all aspects of patient examination be it historical, roent-

genological, physical, laboratory or psychological;

(2) provide a volume and variety of cases such as to provide the externs with the experience necessary to develop and perfect the skills necessary for a D.C. to diagnose, and refer to other specialities; and

(3) provide experience which will ensure that each extern demonstrates acceptable competency levels in clinical skills and for the development of poise and confidence in the extern.

Additionally, CCE requirements also suggest that clinics:

(1) attractively house the number of active patients appropriate to the size of the student body;

(2) provide space and teaching facilities for a clinical staff large enough to permit substantial individual exchange;

(3) maintain a clinic staff sufficient in number and credentials to insure the development of a high level of skills in the student; and,

(4) encourgae and provide programs and facilities whereby the externs and clinic staff may participate in instructionally related research.

FACULTY STUDENT RATIO

Currently, CCE requirements mandate that a faculty-student ratio of 1:15 be maintained at a CCE approved school. However, the actual ratio of full time faculty to D.C. students averages 1:13 and ranges from 1:9 to 1:24.

LICENSING OF A DOCTOR OF CHIROPRACTIC

Since the practice of chiropractic is subject to the laws of the states, responsibility for evaluating competency and qualifications of those desiring to enter chiropractic practice has been given to the licensure boards within the individual states. These licensing boards administer clinical examinations to all candidates, and also evaluate the candidate's knowledge and understanding in the art and science of chiropractic.

However, most D.C. students take a two-part exam administered by the National Board of Chiropractic Examiners. This "national Board" permits evaluation in twelve areas which the candidates must be fully competent. Candidates who have successfully demonstrated their knowledge in all subjects may be exempt from written examinations in the 48 states who recognize these examinations. A national program of this type is valuable to state licensing boards since it provides them with candidate scores based upon examinations given to graduates of all chiropractic colleges. State boards who waive their written examinations and opt for the national boards find that more attention can be given to the administration and evaluation of clinical examinations.

The first part of the exam, either national or state, tests the basic science subjects. These are the same subjects that other health professional including M.D.s and D.O.s must take. Included are: anatomy, physiology, chemistry, pathology, diagnosis, hygiene and public health. The second part of the board is a more specialized test which examines the candidates' expertise in chiropractic. Examples of subjects examined include: principles and practice of chiropractic, and spinal adjusting. neurology and orthopedics, x-ray technique and diagnosis.

Only after passing this rigid examination and only after the state board fully investigates the candidates educational and personal background can a candidate practice in the state. After this intensive training the chiropractor is fully competent and equiped to make neurological and orthopedic examinations, to administer spinal adjustments or manipulation when required, and to identify conditions which lie outside the chiropractor's scope of care and/or contraindicate manual spinal manipulation.

SUMMARY ON EDUCATION

The requirements outlined herein, demonstrate that the education provided to a chiropractic student and the licensing requirements he or she must meet are sufficiently rigid to assure that only a highly skilled and trained specialist is allowed to practice. As was reported by the Commission of Inquiry on Chiropractic in New Zealand p. 234-235:

> While the specific chiropractic courses are not taught outside chiropractic colleges, there is much other material that is ... more than half the contact hours in the 4- to 5- year course offered are concerned with just those topics which are to be found in any standard preclinical medical course. The chiropractic student is therefore well exposed to anatomy, physiology, and diagnosis (including laboratory procedures) and in a CCE college he will probably be taught these subjects by a non-chiropractor using standard medical texts. He is therefore exposed to the whole range of scientifically based factual material as medical students are.

PART II

CHIROPRACTIC AND HEALTH MANPOWER

The geographic maldistribution of chiropractors is one issue the federal government has to address. Although the national ratio of chiropractors to the population is 10.1 per 100,000, these chiropractors are not evenly distributed across the United States. The variation ranges from a high of 23.2 per 100,000 in Iowa to a low of 0.9 per 100,000 in the District of Columbia. (see appendix) The regional distribution of chiropractors also varies significantly ranging from 6.8 per 100,000 in the New England States to 15.2 per 100,000 in the Pacific States. (see appendix) This maldistribution problem is particularly acute in the cities where less than 30% of the chiropractic profession practices.

Considering that there are no intrinsic differences across states in their "need" for chiropractic services, the large differences in density of D.C.s indicates a very large potential demand in the lower density areas. One would certainly expect that the degree to which the public is well informed about chiropractic and its availability would directly affect the level of service utilization in the area. A recent study funded in part by the federal government reported that 49 percent of a local population would utilize chiropractic services if it were available in a community health plan.

To adequately serve the health care needs of this country, the federal government should address the issue of severe geographic maldistribution and urban-rural maldistribution of chiropractors in the United States.

Added to this problem within chiropractic is the severe underrepresentation of women and minorities within the profession. Currently, less than 10 percent of chiropractic students are female and less than 1 percent are members of minority groups. Such inequities indicate that a sizeable portion of our population is not receiving needed care.

We wholeheartedly agree with the premise that health professional schools are a national resource and bear a special responsibility to help solve the health manpower problems of this nation. But to do this, the schools must be financially stable. All our chiropractic colleges are private, freestanding institutions; they are neither public institutions which have the government as a primary sponsor nor are they parts of universities on which to rely for financial support. Their financial status is often dangerously close to bankruptcy. Added to these problems are inflation, which erodes the value of each revenue dollar, and the increased and unfulfilled need for more programs and capital improvements.

The chiropractic institutions receive virtually no government support, from neither federal nor state and local sources. Indeed, the states and local communities cannot be expected to meet the needs of the colleges since these programs would have to address national goals.

Our institutions have to rely on ongoing campaigns for philanthropic support. These gifts are being used to meet the obligations for capital improvements which must be made and are merely enough to maintain the status quo and keep the colleges solvent. Little if any funds are available for special projects, improvements of facilities, continuing education, more advanced clinical training, or recruitment of women and minority students. Added to this problem is the fact that practicing Doctors of Chiropractic cannot be attracted to faculty positions since field doctors earn three times as much as faculty members within the profession.

The funding needs of our colleges are so large, and need for new programs and improvements so great, that only through federal support of institutions as provided under a health manpower program could their needs be met. Otherwise, the only other reasonable and secured source available for such substantial sums is the student tuition.

We agree that students should be responsible for a large share of their professional education, simply because Doctors of Chiropractic share with other health professionals the enviable position of earning incomes in the nation's highest bracket. However, gross inequities are obvious when you compare the percentage of operating costs covered by tuition at chiropractic institutions with that covered by tuition at other health profession's institutions. Tuition and fees currently comprise almost 70% of our colleges' operating incomes. This figure is in sharp contrast to the 9.9 percent for the eight health professional groups studied in the 1972 Institute of Medicine Report. This problem is aggravated by the fact that chiropractic students have little or no income and few loans or scholarship programs are available to them, at least not to the extent that aid is available to other health profession's students.

Therefore, we respectfully request that Federal legislation be enacted under health manpower programs to provide assistance to our educational institutions and students.

INSTITUTIONAL SUPPORT

One particular problem which faces our colleges is that some 40 states require that new practitioners be graduates of CCE approved schools. Since the CCE is a recent development, the majority of our schools are only recently attempting to attain accreditation. Often, resources are stretched to the limit in order to meet a specific CCE requirement. This channeling of funds hurts the student directly since one school's program has to be "sacrificed" for another program. Pressures on the colleges are tremendous to meet accreditation requirements since without this status potential students will not attend since their "career" options would be limited to a few states. The quality of education not only suffers but their continued operation is in jeapordy.

Presently, chiropractic colleges have no incentive to meet the problems of geographic maldistribution and inadequate female and minority representation in the profession. The schools have tremendous problems just meeting the needs of the current student population, much less recruiting and meeting the needs of students from underserved communities or minorities and women. Our colleges, as free standing independent institutior are in need of capital improvements. Many of their facilities were constructed years ago when the size of the student body and the demand for chiropractic services were far smaller than they are now. Many facilities are inadequate for contemporary quality chiropractic education and must be renovated. Satellite clinical centers are needed by many of our schools to provide not only a sufficient range of clinical experience for our students, but to provide service to many of our underserved and elderly citizens that travel great distances to receive care at our present clinics. Without federal funding in some form, our colleges will not be able to meet the needs for adequate teaching facilities. Progress and advancement in chiropractic education will move along at a pace which will not best serve the needs of this nation or of the strong commitment the federal government has made for health professional education.

The evolution of modern medicine and allied health professional education during the last thirty years has been closely tied to federal funding. Federal money has been granted to fund education in medicine, dentistry, osteopathy, podiatry, optometry, veterinary medicine, nursing, public health and pharmacy -- every aspect of the health care system except chiropractic. The exclusion of chiropractic from federal health manpower funds places the profession at a disadvantage in the maintenance of quality education. The exclusion is not in the best interest of either the public or this country's health care delivery system; nor is it consistent with many different federal programs which include chiropractic services.

Therefore, we respectfully request that when the present health manpower act is revised, it be amended to specifically provide for institutional support to chiropractic colleges. The items we feel this program should contain are:

(1) FINANCIAL ASSISTANCE GRANTS FOR NEW INSTITUTIONS

Within the past few years, four different chiropractic colleges have opened classes for the training of Doctors of Chiropractic. As the acceptance,[*] recognition and demand for chiropractic services increases, the need for new facilities will certainly increase. These new institutions will face tough, if not impossible, demands for financing unless federal funds are available for beginning faculty recruitment, equipment, facilities, library resources and other needs.

(2) FINANCIAL DISTRESS GRANTS

Our chiropractic colleges are not immune to the ever increasing burden of inflation. Added to this problem is the need to improve facilities and curriculum of existing schools at a standard which will assure and maintain accreditation, and most important, to open new facilities at a level that achieves accreditation. Therefore, our colleges should be allowed to participate in financial distress programs when they face serious financial problems; when they are in need of meeting, maintaining or seeking accreditation requirements; and for the carrying out of appropriate, operational managerial and financial reforms.

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[*] Recent indications of greater public acceptance can be shown by the appointment of two chiropractors to the United States Olympic Council on Sports Medicine. (appendix 1)

(3) CONSTRUCTION ASSISTANCE

Chiropractic colleges should be able to participate in any federally funded construction loan program. Without this source of security, many new facilities which are now inadequate could not be renovated or improved.

(4) SPECIAL PROJECT GRANTS

The Secretary should be allowed to make grants to chiropractic colleges to encourage the development of policies to attract and recruit students who are from medically underserved areas. The Secretary should also be allowed to make grants to chiropractic colleges which develop programs to provide services to areas which are medically underserved.

The particular needs of the medically underserved are no different from the millions of other citizens who seek chiropractic services. Additionally, the poor and the elderly have been in the past the most dependent users of chiropractic care. Often many of these individuals do not receive chiropractic care because of the great distances that have to be traveled to participate in the clinics. Our colleges would be most anxious to start programs that would provide needed care to the underserved and elderly who are far removed from our present facilities. Currently, lack of funds have prevented the establishment of such programs.

Project grants should be allotted for the development of didactic or clinical education especially continuing education and residency training in geriatrics, orthopedics and neurology, roentgenology, chiropractic technique, and clinical teaching methods.

(5) GRANTS

Additionally, chiropractic colleges should fully participate in any grant-giving program, be it grants for "national priority incentive programs" as in HR.6802 or in the present capitation grants program if there is an extension of the current law. Such grants would virtually assure that chiropractic education reach contemporary needs and would expand the current state of chiropractic science. This is especially true since our colleges have never been the recipients of any federal funds.

STUDENT FINANCIAL ASSISTANCE

Doctors of chiropractic can provide valuable health and clinical services in the National Health Service Corps but have not had this opportunity. Doctors of Chiropractic will provide a professional and competent new dimension to the many community health care centers of many rural and urban underserved areas.

Scholarship and loan programs are necessary so that students will have an option and opportunity to acquire a chiropractic education when family or personal financial resources are inadequate or desperately short to meet educational costs. Without such programs, chiropractic colleges will remain the place for only the wealthy and white. These new programs would also assure that quality students would not be turned down from pursuing a career in chiropractic because the federal government does not provide financial support, as it does with other health care providers.

The chiropractic students should be included and should participate in financial aid programs such as:

(1) The National Health Service Corps Scholarships. A new NHSC program should clearly provide for the participation of chiropractic students. A set number of scholarships should be awarded to chiropractic students annually and the same number of entry level NHSC positions should be held for doctor of chiropractic in each year of a new authorization.

(2) Exceptional Financial Need Scholarship (EFN) The Secretary should be authorized to provide

grants to status holding chiropractic institutions for the awarding of scholarship grants to full-time students who are of exceptional financial need.

(3) Service Contingent Loan Program

Current law should be amended to include and provide that the Secretary shall enter into agreements at the request of chiropractic colleges to establish and operate a service contingent student loan program.

(4) Health Professions Student Loan Program

Any extension of the current Health Profession Student Loan Program, which we understand to be the most popular of the student assistance programs under current law, should specifically provide for chiropractic student participation.

(5) Federal Loan Insurance Program

Current law should be amended to include the participation of chiropractic students in the federal program for insured loans.

NATIONAL ADVISORY COUNCIL
ON HEALTH PERSONNEL

The particular manpower problems of chiropractic would necessitate that the Department of Health and Human Services implement and maintain a systematic and ongoing program for the collection of data on chiropractic. Therefore, we respectfully request that legislation be adopted for the purpose of assuring that such data collecting is implemented and maintained by the appropriate division within the Department.

CONCLUSION

Chiropractic colleges are a unique national resource providing the sole quality education and instruction in the principle of spinal manipulative therapy. The Congress has several times recognized the unique contribution that chiropractic can make in alleviating health care problems in this country. The American citizenry utilizes and demands chiropractic care.

The time has come for the Congress to follow through with this recognition by designing legislation which will allow our colleges (and students) to participate as a separate and equal partner in the federally funded health manpower training programs. This legislation would assure that quality education be maintained. Our profession is dedicated to the ever present need to train primary care practitioners that specialize in spinal manipulative therapy. Our colleges are well qualified to meet this need. We look forward to an opportunity to meet with individuals directly involved in shaping the nation's health manpower policy, and we are anxious for ongoing and mutually productive dialogue. We would be most happy to provide any other information which may be needed. Thank you.

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STATEMENT OF ALAN M. DINSMORE, SPECIALIST IN GOVERNMENTAL RELATIONS, AMERICAN FOUNDATION FOR THE BLIND, THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT, COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE, U. S. HOUSE OF REPRESENTATIVES, ON PENDING HEALTH MANPOWER LEGISLATION, APRIL 1, 1980.

Mr. Chairman and members of the Subcommittee, I appreciate this opportunity to present the views of three national organizations concerning legislation to revise and extend Title VII - Health Research and Teaching Facilities and Training of Professional Health Personnel - of the Public Health Service Act.

The three organizations I am representing are the American Association of Workers for the Blind, the national membership organization of professional workers serving blind persons; the American Foundation for the Blind, the national voluntary research and consultant agency in services to blind persons of all ages; and the Blinded Veterans Association, the Congressionally chartered membership organization of the Nation's warblinded.

All three of these organizations are interested in the approaches taken by H.R. 6802 regarding project grants, traineeships, and assistance to disadvantaged individuals under Part F "Allied Health Personnel" as they pertain to rehabilitation. We are particularly interested in the training under allied health authority of three types of allied health professionals to meet the unique needs of blind and severely visually impaired persons. These are: (1) the low-vision technician, who trains a severely visually impaired individual in the use of low vision aids (various kinds of lens systems) to enable him to make maximum use of residual vision; (2) the orientation and mobility specialist, who trains a blind individual in techniques which enable him to walk safely and remain oriented in a variety of settings without the use of sight; and (3) the rehabilitation teacher, who trains a blind person a variety of personal management skills, exclusive of mobility skills, to enable him to achieve maximum functional independence without sight.

Comprehensive low vision service has as its objective the attainment of optimum visual efficiency in legally blind and severely visually impaired individuals. Effective low vision service requires vision evaluation, optical aid prescription, and the training of the patient on a team basis. These procedures require a detailed opthamological examination, an optometric low vision examination, and specialized training of the patient by a low vision technician in the use of the prescribed low vision aid.

To our way of thinking, shortages in orientation and mobility, rehabilitation teaching, and low vision technician personnel become critical when viewed in the context of the following factors:

- Severe vision loss, including blindness, now affects more persons over 65 than all other age groups combined. And AFB projections based on National Center for Health Statistics rates forecast that, in the 20 years remaining before the year 2000, blindness and severe vision impairment among the 65 plus age group will increase by one-third. Program planning and service delivery by low vision professionals to this population becomes even more an issue for the extension of authorities under Title VII because evidence provided to the U.S. Senate's Special Committee on Aging shows that 38 percent of the Nation's elderly live in rural, medically underserved areas
- P.L. 94-142, "The Education for All Handicapped Children" Act mandates "free appropriate public education...to meet the unique needs of a handicapped child, at no cost to parents or guardians." While the Act specifies the provision of "related services" it does not specify who pays the bill and provides no assistance for training health and rehabilitation professionals who, particularly because of the

"mainstreaming" features of the law, must now serve a more widely dispersed population.

Education of the Handicapped Act, as amended by Public Law 94-142:

- "(17) the term 'related services' means transportation, and such developmental corrective, and other supportive services (including speech pathology and audiology, psychological services, physical and occupational therapy, recreation, and medical and counseling services, except that such medical services shall be for diagnostic and evaluation purposes only) as may be required to assist a handicapped child to benefit from special education, and includes the early identification and assessment of handicapping conditions in children."

- The Rehabilitation Act of 1973 as amended by The Rehabilitation, Comprehensive Services and Developmental Disabilities Amendments of 1978 (P.L. 95-602) provides new authority supported by appropriations for independent living skills and special programs for the blind who, because of the severity of disability, may not qualify for more conventional vocational rehabilitation programs.

We are very much concerned that these federal mandates, while providing the basis for innovative and very much needed programs, are based on the assumption that present training authorities for orientation and mobility specialists, rehabilitation teachers, and low-vision technicians are geared to providing sufficient numbers of new professionals.

Not only are they not geared by level of appropriations support, present authority for training is not suitable for providing for assisting the new populations who must be served under federal law. For example, several colleges and universities are providing training for orientation and mobility specialists with financial assistance from the Rehabilitation Services Administration and the Office of Education. The principle purpose of these two authorities is to train blind and severely visually impaired children and adults with vocational rehabilitation potential. Yet, the vast majority of newly blind individuals lose their sight after the optimum age for vocational rehabilitation.

A further point, unlike the approaches provided by bills under consideration by your Subcommittee, present training authorities for professionals in service to the blind provide little or no assistance in either interdisciplinary training or upgrading of basic skills..

Training in blindness rehabilitation, because of these limitations, does not prepare workers adequately for the number and types of multi impaired clients they may encounter. And, although individual programs at their own initiative have developed new techniques, no wide-based training authority exists to implement these programs. As a result, much of the rehabilitation expertise designed to teach individuals how to compensate for loss of sight is undermined when potentially compensating physical, sensory, or mental capabilities are also impaired.

Some measure of the necessity for dealing with the problem can be derived from a 1977 Health Interview Survey prepared by the National Center for Health Statistics which shows that, even excluding many chronic conditions, a majority of severely visually impaired persons have one or more additional impairments. For example, the incidence of multiple impairment including severe vision loss rises to 66 percent of the 65 plus population.

Traditional service patterns for those populations have had a heavy institutional/residential emphasis. Recent developments, primarily deinstitutionalization for the mentally disabled with attendant emphasis on community living in the least restrictive housing situation and emerging programs emphasizing community living alternatives versus nursing home care, are changing these patterns. For example, in New York state, an increasing number of multi-handicapped blind persons from such institutions as Willowbrook State School, the Suffolk County Developmental Center, Pilgrim State Hospital and others are being referred for rehabilitation services to community-based agencies for training in skills like orientation and mobility and independent living skills taught by rehabilitation teachers for the blind.

The present Training Authorities provide little or no support for development of advanced skills to serve the multi-handicapped child. Further, local and state funding is simply not designed to support the training of students whose services are typically needed in areas outside of the state or local area. In this case, employment of these Blind Rehabilitation Specialists follows the general trend of allied health personnel-wide geographic dispersement after training.

By the end of 1980, there will be approximately 1,000 rehabilitation teachers working within the field of blindness. Presently five (5) universities specialize in training rehabilitation teachers for the field of blindness. Current sources of funding have remained level while predictable increases in service needs indicate the need to develop at least five (5) more university level training programs. The rehabilitation teacher will be particularly important in teaching personal management skills exclusive of mobility to elderly blind persons in their own homes and deinstitutionalized multi-handicapped blind persons in new community living arrangements.

There are now about 1,200 orientation and mobility specialists employed by public and private non-profit rehabilitation facilities, public and private agencies for the blind, residential schools for the blind, and various public school programs. Yet, a safe estimate is that not much more than 25 percent of the visually handicapped who could profit from orientation and mobility training have received such training from a certified instructor. Twelve universities offer programs in this specialty and each year there are approximately 100 graduates from these programs who enter the field. Establishment of continuing education program authority for graduates of these programs is needed if these health professionals are to offer the new services required by the multi-handicapped blind and a large numbers of unserved elderly blind.

Therefore, we are pleased to note the H.R. 6802's proposed retention of Allied Health Personnel project grants, traineeships and assistance of disadvantaged individuals.

However, we urge the Subcommittee to reconsider the authorization levels proposed by H.R. 6802. The National Commission of Allied Health Education has pointed out that, as of 1978, an estimated 3.5 million individuals (nearly 66 percent of the total health-care work force) could be classified, in the broadest sense, as Allied Health practitioners. The Health Resources Administration's Bureau of Health Manpower in a report on Allied Health required by Section 702(d) of the Health Professions Educational Assistance Act of 1976, P.L. 94-484, points out still existing shortages in certain allied health specialities. In light of this information, we recommend that the authorization levels for the proposed Section 235-Project Grants, Section 236-Traineeships, and Section 237-Assistance to Disadvantaged Individuals be adjusted as follows: Section 235--$30 million for fiscal 1981, $32 million for fiscal 1982, and $36 million for fiscal 1983; Section 236--$5.5 million for fiscal years 1981, 1982, and 1983; Section 237--$1 million for fiscal years 1981, 1982, and 1983.

Finally, since Title VII of the Public Health Service Act grants the Secretary of Health, Education, and Welfare broad authority in designating the types of allied health professionals who can be trained under its provisions, we urge the Committee to include in its report accompanying proposed legislation to extend health manpower programs specific intent language directing the Secretary to initiate programs at institutions of higher learning for training of low vision technicians, mobility specialists for the blind and rehabilitation teachers of the blind.

STATEMENT OF NEW YORK CITY,
OFFICE OF CITY COUNCIL PRESIDENT

Mr. Chairman, Members of the Subcommittee:

Thank you for giving me this opportunity to submit testimony on foreign medical graduates (FMG's) in New York City teaching hospitals.

The National Health Professions Educational Assistance Act of 1976 tightened the educational standards and visa qualifications necessary for foreign medical graduates desiring to enter the United States for post-graduate training. It also imposed a two-year time limit on such training programs, with an optional third year if requested by the FMG's home country.

The potential adverse consequences of this change in policy did not go unnoticed by Congress. The 1976 legislators provided a phase-in period which waives the more stringent educational requirements if a particular training program can demonstrate that a "substantial disruption in medical services" would otherwise occur. This phase-in period runs out in December, 1980, at which time the more restrictive immigration requirements will have full force and effect.

New York City will face a critical doctor shortage in the coming months unless present law is revised to:

- Postpone implementation of these restrictions until December 31, 1985;
- Allow FMG's entering the country under new restrictions to stay long enough to complete their training program (usually four to five years);
- Permit National Health Service Corps doctors the

> OPTION OF USING POSTGRADUATE TRAINING IN SOME INSTANCES, AS FULFILLMENT OF THEIR SERVICE OBLIGATION. UNDER THE CURRENT LAW, CORPS DOCTORS RECEIVE ASSISTANCE IN EXCHANGE FOR PAYBACK SERVICE IN MEDICALLY UNDER-SERVED AREAS ONLY AFTER TRAINING IS COMPLETED. PRESENT LAW ALSO PRECLUDES ANY CORPS SERVICE IN MUNICIPAL HOSPITALS.

FOREIGN MEDICAL GRADUATES (FMG'S) NOW ACCOUNT FOR APPROXIMATELY 40 PERCENT OF ALL INTERNS AND RESIDENTS IN ALL NEW YORK CITY HOSPITALS. LOSS OF THESE DOCTORS WILL JEOPARDIZE CITY HEALTH SERVICES AND AFFECT THOSE WHO HAVE THE GREATEST NEED - THE POOR WHO RELY ON DOCTORS AS THEIR FAMILY PHYSICIANS.

APPENDED TO THIS TESTIMONY IS A REPORT PREPARED BY MY OFFICE WHICH DETAILS THE ADVERSE IMPACT OF THE 1976 IMMIGRATION AMENDMENTS ON NEW YORK CITY HOSPITALS, PARTICULARLY MUNICIPAL INSTITUTIONS, AND OFFERS RECOMMENDATIONS TO MINIMIZE THIS IMPACT.

AS THE REPORT DOCUMENTS:

- THE LOSS OF FMG'S WILL BE MOST SEVERELY FELT IN THE INDUSTRIALIZED SECTIONS OF THE NORTHEAST AND NORTH-CENTRAL STATES. NEW YORK CITY IS, AND WILL CONTINUE TO BE, PARTICULARLY HARD HIT. THE CITY - WITH ITS LARGE CONCENTRATION OF TEACHING HOSPITALS - NOW TRAINS ONE OF EVERY TWELVE PHYSICIANS NATIONWIDE. AS PART OF THEIR TRAINING INTERNS AND RESIDENTS DELIVER ESSENTIAL MEDICAL SERVICES TO MANY NEW YORKERS.

- OF THE 8,103 DOCTORS TRAINING IN VOLUNTARY AND MUNICIPAL HOSPITALS IN NEW YORK CITY IN 1978, 3,056 -- 38 PERCENT -- WERE FMG'S. THESE FOREIGN DOCTORS AMOUNT TO MORE THAN 50 PERCENT OF THE HOUSESTAFF IN TWENTY-THREE HOSPITALS, AND IN TWELVE OF THESE INSTITUTIONS, THE PROPORTION OF FMG'S IS MORE THAN 75 PERCENT. FOR INSTANCE, AT HARLEM HOSPITAL, FOREIGN MEDICAL GRADUATES HOLD 100 PERCENT OF ALL HOUSESTAFF POSITIONS IN PATHOLOGY AND ANESTHESIOLOGY, 86 PERCENT IN PEDIATRICS AND 78 PERCENT IN PSYCHIATRY. AND IN BROOKLYN, WHERE FMG'S MAKE UP 93 PERCENT OF ALL PEDIATRICIANS AT THE HEALTH AND HOSPITALS CORPORATION FACILITIES, THE BOROUGH COULD BE LEFT WITHOUT CHILDREN'S SERVICES IN MUNICIPAL HOSPITALS SHOULD THE RESTRICTIVE IMMIGRATION REQUIREMENTS GO INTO FULL EFFECT. TABLES I-VII OF MY REPORT FURTHER DETAIL THE IMPACT OF REDUCED FOREIGN DOCTORS ON HOSPITAL-BASED SERVICES, PARTICULARLY IN PRIMARY CARE.

I AGREE WITH THE FEDERAL POLICY ON FMG'S. I TOO AM CONCERNED ABOUT THE "BRAIN DRAIN" FROM PHYSICIAN-POOR COUNTRIES TO THE UNITED STATES. FROM 1966 TO 1977, A 6 PERCENT ANNUAL INCREASE IN THE NUMBER OF AMERICAN MEDICAL GRADUATES HAS HELPED TO ALLEVIATE THE PHYSICIAN SHORTAGE OF THE EARLY SIXTIES WHICH JUSTIFIED LIBERAL IMMIGRATION POLICY.

Until recently, the hospital community in New York City, including the Health and Hospital Corporation, had not used the time already allowed by the federal government to seek replacements for FMG's. Therefore, a suitable plan for seeking competent medical personnel to fill vacancies left by the shrinking pool of qualified FMG's must be a part of any interim stop-gap measures. The Corporation has already made a commitment to develop and implement such a plan.

However, we need time and federal assistance to avoid real reductions in physician services. In order to provide us with that time and assistance I have recommended the following legislation:

1) The phase-in period of the law must be extended from December 31, 1980 to December 31, 1985, allowing the federal government to continue granting waivers to avoid a "substantial disruption of health services." Of the 145 waivers granted nationally, between 1978 - 1980, 107 were for New York City hospitals. As of February, 1980, 95 of the 96 national waivers pending came from New York City.

2) Coordinate the length of a foreign doctor's stay in the United States with the length of the training program. Alien physicians who come to the United States for graduate medical education, and who

OTHERWISE QUALIFY FOR ENTRY, SHOULD BE ALLOWED TO REMAIN FOR A PERIOD EQUAL TO THE LENGTH OF THEIR PROGRAM. THIS WOULD ENABLE FMG'S TO RETURN HOME WITH APPROPRIATE SKILLS. ALSO, MEDICAL CARE WOULD NOT BE COMPROMISED BY SHORTAGES OF UPPER-LEVEL RESIDENT PHYSICIANS, CREATED BY THE FORCED DEPARTURE OF FMG'S AFTER TWO YEARS.

3) INCLUDE MUNICIPAL AND VOLUNTARY HOSPITAL TRAINING PROGRAMS IN NATIONAL HEALTH CORPS SERVICE COMMITMENTS. THE LAW SHOULD BE AMENDED TO ALLOW PARTICIPATION IN DESIGNATED TRAINING PROGRAMS IN VOLUNTARY AND MUNICIPAL HOSPITALS TO FULFILL THE PHYSICIAN'S SERVICE OBLIGATION. PROGRAMS SHOULD BE DESIGNATED ONLY,

- IF THEY INVOLVE PRIMARY CARE SPECIALTIES IN MEDICALLY UNDERSERVED AREAS;
- ARE IN DEPARTMENTS CURRENTLY DEPENDENT ON FMG'S FOR THE PROVISION OF CARE;

IN ENACTING THIS LEGISLATION, WE MUST NOT LOSE SIGHT OF THE LARGER ISSUE OF MALDISTRIBUTION-BY SPECIALTY AND GEOGRAPHY OF PHYSICIANS TRAINED HERE IN THE UNITED STATES.

REDISTRIBUTING MEDICAL PERSONNEL, SO THAT ALL SPECIALTIES AND REGIONS ARE SUFFICIENTLY COVERED AND ACCESS TO HEALTH CARE IS ASSURED FOR THE POOR AND WORKING CLASS, DEPENDS ON REORDERING THE PRIORITIES OF AMERICAN MEDICAL EDUCATION. IT RESTS WITH HEALTH POLICY-MAKERS, BOTH PUBLIC AND PRIVATE, AND PHYSICIANS THEMSELVES TO DEVELOP A COHERENT MEDICAL POLICY TO ACCOMPLISH THESE GOALS.

THANK YOU FOR THE OPPORTUNITY TO SUBMIT MY VIEWS.

Acknowledgements

This report was authored by Stella Schindler, with the assistance of Barry Ensminger of the New York City Council President's Office. The author is especially grateful for expertise provided by Robert DeCresce, M.D., M.B.A., Assistant Professor of Pathology, Downstate Medical School.

We would also like to thank Council President staff members: Charles Perkins, Lynne Abraham, Denise Duchemin, Susan Solomon and Olka Harbor, for their help.

We appreciate comments provided by Charles Davenport Cook, M.D., Chief of Pediatrics, Downstate Medical Center; Harold Ratner, M.D., Chief of Pediatrics, Greenpoint Hospital; and Hugh Evans, M.D., Chief of Pediatrics, Brooklyn Jewish Hospital; as well as the cooperation of the New York City Health and Hospitals Corporation.

I. SUMMARY

This report focuses on a health care crisis New York City must soon face: a critical doctor shortage in municipal and voluntary hospitals because of new restrictive immigration policies for foreign-born graduates of foreign medical schools. The loss of these foreign medical graduates -- or FMG's -- will impact severely on the delivery of municipal health care services (especially in certain specialties and certain boroughs) and will have important fiscal implications for the City as well.

In 1976 Congress passed the Health Professions Educational Assistance Act, which ended a national policy of preferential treatment for FMG's seeking entry visas to the United States. At that time, FMG's represented 21 percent of the nation's physicians, many of whom worked as interns and residents in urban areas in the Northeast, particularly New York.

The consequences of the new policy did not go unnoticed. A 1978 article in the prestigious New England Journal of Medicine considered the national implications; a study by the New York State Health Planning Commission looked at the FMG situation statewide. (Some of their respective data are cited in this report.) But despite these studies, New York City took little action to confront the impending problem. This report, which has been and will continue to be used as a lobbying tool to press for recommended federal legislation, details how the doctor shortage will impact on municipal hospitals, and breaks down contemplated costs for replacement medical personnel in HHC institutions.

Attracted by New York's cosmopolitan image and the large numbers of teaching hospitals here, FMG's have traditionally concentrated in the City, working in older facilities in poor inner-city neighborhoods usually shunned by their American counterparts.

Foreign medical graduates now hold about 40 percent of all intern and resident positions in New York City. The new immigration restrictions, which take effect after December 31, 1980, are expected to ultimately cut the FMG population by two-thirds, from 3,056 in 1978 to fewer than 1,100 by 1984.

The reduction of foreign physicians will cripple some City hospitals, while barely affecting others. Large, prestigious institutions will continue to recruit the top students from American medical schools, while deficit-ridden hospitals will find their staffs cut drastically. In 12 New York hospitals, FMG's now represent more than 75% of the housestaff (interns and residents) and their departure could result in severe disruptions. The reduced pool of FMG's will cause the greatest problems in facilities run by the Health and Hospitals Corporation (HHC), which trains more than 40% of the foreign graduates in New York. The HHC dependence on FMG's will be felt more in certain specialties -- pediatrics, anesthesiology and gynecology -- and certain boroughs -- Brooklyn, Queens and Manhattan. An extreme example of the FMG loss: FMG's now make up 93% of HHC pediatricians in Brooklyn and the new policy could leave the borough without any children's services in its municipal hospitals.

One option available to HHC would be to replace FMG's with attending physicians and physician extenders, thus driving up medical personnel costs. If this course is followed, the Council President's Office conservatively estimates that costs will rise $4.4 million in 1981, $9.9 million in 1982, $15.4 million in 1983 and $21 million in 1984.

To minimize the impact of the upcoming doctor shortage, this report recommends that Congress:

- Postpone implementation of the new immigration restrictions until December 31, 1985 giving the City more time to prepare for the reduction of FMG's.

- Allow FMG's entering the country under the new restrictions to stay long enough to complete their training program (usually four to five years). The law now imposes a two year limit.

- Permit National Health Service Corps doctors to use postgraduate training as fulfillment of their service obligation. Under the current law, Corps doctors receive tuition assistance in exchange for payback service in medically-underserved areas only after training is completed. Present law also precludes any Corps service in municipal hospitals.

In addition, New York City should:

- Intensify its recruitment of American trained physicians, many of whom attended medical schools in the city.

- Step up recruitment of American graduates of foreign medical schools, many of whom are originally from New York.

- Reduce surplus housestaff positions.

II. HISTORY

Over the past two decades, foreign-born graduates of overseas medical schools have played an increasingly prominent role in the delivery of health services in the United States. They often serve in inner-city hospitals lacking doctors and enter specialties, such as pediatrics, gynecology and anesthesiology, which are frequently shunned by their American counterparts.

More than one-fourth of the nation's foreign medical graduates (FMG's) receive training in New York City, which cannot attract enough American graduates to its large number of teaching hospitals in poor and medically underserved neighborhoods.

Concerned about the nationwide shortage of doctors in the 1960's, the federal government encouraged the influx of foreign medical graduates. The usual immigration requirements were waived for foreign doctors in 1965 amendments to the Immigration and Naturalization Act. These amendments exempted foreign physicians from the national origins quota system, thus providing easier access to the United States. Between 1965 and 1975 an average of 7,375 foreign medical graduates entered the country every year, receiving valuable training in U.S. hospitals and providing essential medical services in return.[1]

Finding the lucrative earning power of American doctors hard to resist, many FMG's converted their temporary permits into permanent visas to stay in the United States. By 1976, FMG's accounted for 85,000 -- or 21% -- of the nation's 409,000 physicians. Many of these doctors set up practice in low-income neighborhoods avoided by U.S. medical graduates.

As thousands of foreign doctors stayed in the United States, their native countries felt the impact of the "brain drain". Leaders of underdeveloped countries asked why their nations should provide expensive medical school training to young men and women, only to see them leave to practice in the United States.

Most of the arriving FMG's, in fact, were from countries badly in need of their own medical personnel. Of the 10,188 foreign doctors in the U.S. training programs in 1977, 6,559 -- or 64% -- were from physician-poor Asia, and only 1,570 -- or 15% -- were from Europe, where doctors are more plentiful. Over 3,993 -- or 39% -- were from India and the Philippines alone, neither of which has an abundance of doctors.[2]

Over the past few years, the need for foreign medical graduates in the U.S. has declined, as increasing numbers of doctors graduated from American medical schools. From 1966 to 1977, a 6% annual increase in the number of U.S. graduates helped alleviate the physician shortage of the early sixties, nearly doubling the number of U.S. medical graduates.[3] Fears of physician surpluses in some sections of the country were voiced with increasing frequency.

Questions were raised as well about the medical qualifications of the FMG's. Critics pointed out that foreign doctors were not scoring as well as American graduates in standardized tests and questioned their proficiency in the English language. Language and cultural barriers often create obstacles to proper treatment and diagnosis, it was argued. Medical experts acknowledge, however, that standardized tests are not always a fair measure, since they test language proficiency and knowledge of basic medical science, rather than the clinical skills needed on a day-to-day basis. Unfortunately, no comprehensive and reliable study has ever compared the quality of medical care provided by American and foreign medical graduates.[4]

Criticism of the physician "brain drain" from other nations, the increasing supply of U.S. medical graduates and continuing concern about the quality of care rendered by foreign medical graduates convinced more and more policymakers to challenge the federal government's liberal immigration policy for doctors. A series of studies -- by the National Advisory Commission of Health Manpower, the Coordinating Council on Medical Education, the Carnegie Council on Policy Studies in Higher Education, the American Association of Medical Colleges and others -- recommended basic changes in federal policy.

III. FEDERAL LAW RESTRICTS ENTRY OF FOREIGN MEDICAL GRADUATES

Congress responded to these growing concerns by passing the National Health Professions Educational Assistance Act of 1976, declaring the United States self-sufficient in physician manpower and ending the national policy of preferential treatment for foreign medical graduates desiring entry visas.[5] The new law tightened the educational standards and visa qualifications necessary for entry in an effort to reduce dependence on foreign medical graduates and assure that those who do enter meet the same standards as American graduates. The law essentially placed foreign medical graduates on the same footing as any other alien trying to enter the country.

Specifically, the law:

1) Raises the educational requirements for entering foreign medical graduates by replacing the Educational Commission for Foreign Medical Graduates test (ECFMG) with the Visa Qualifying Examination (VQE). The new test, stressing basic medical science and English proficiency, is significantly more difficult. In 1977, when both exams were offered, 33% of the participating foreign medical graduates passed the Educational Commission for Foreign Medical Graduates exam compared with less than 25% for the Visa Qualifying Examination.

2) Imposes a two-year time limit on training programs with an optional third year if requested by the foreign medical graduate's home country. (Since this period is shorter than most approved residency programs, the attractiveness of American graduate medical education is greatly diminished.)

3) Eliminates the favored status of foreign medical graduates and the occupational preference entitling them to Immigrant Visas. Foreign medical graduates are now required to enter the United States on Exchange Visas which, unlike Immigrant Visas, cannot be converted to allow permanent residence.

Hospitals and medical schools can have the Visa Qualifying Examination requirement waived for individual training programs until December 31, 1980, if they demonstrate that a "substantial disruption in medical services" would otherwise occur.[6]

Not affected by the change in law are American graduates of foreign medical schools, since the immigration restrictions only affect the foreign-born.

IV. LOSS OF FOREIGN MEDICAL GRADUATES MOST SEVERE IN NORTHEAST AND NEW YORK CITY

The 1976 law greatly reduces the pool of foreign medical graduates eligible for entry into the United States each year, cutting the annual supply of FMG's by two-thirds -- from 7,500 to 2,500 -- by 1980 or 1981, according to a 1978 forecast by the Department of Health and Human Services (formerly Health, Education and Welfare).[7] Foreign medical graduates beginning four to five year long residency programs before December 31, 1980 will still be able to enter the country under the waiver provision. The full impact of the law, however, will not be felt until 1985, when the 1980 group will have graduated, and virtually all foreign medical graduates in the country will have entered under the stricter regulations.

The loss of FMG's will be most severely felt in the industrialized sections of the northeast and northcentral states, where hospitals have traditionally relied upon the foreign doctors.

New York City is and will continue to be particularly hard hit. The New York State Health Planning Commission predicts the number of foreign graduates in New York City will drop from 3,056 in 1978 to between 1,050 and 1,100 by 1984 as foreign medical graduates move on to new positions or return home and are not replaced. The City, with its large concentration of teaching hospitals, now trains one of every 12 physicians nationwide and relies upon these trainees to provide many essential services. Of the 8,103 doctors training in voluntary and municipal hospitals in New York City in 1978, 3,056 -- or 38% -- were foreign medical graduates.[8]

This high proportion of FMG's stems from the problem many City hospitals face when recruiting U.S. medical graduates. Elite Manhattan hospitals can easily attract interns and residents from top medical schools, but attempts to enroll these students for graduate training in aging and deficit-ridden, inner-city hospitals have been difficult in the past and are not getting any easier. Students are uncertain about the future of New York's troubled hospitals; 27 private hospitals have filed for bankruptcy since 1975, several municipal facilities are scheduled to be closed, and there is an overall shortage of nurses, equipment and medical supplies. Medical students also cite high crime rates and the deteriorated condition of inner-city neighborhoods where many municipal and small voluntary hospitals are located.

Thus, the reduction of foreign medical graduates in New York will have an uneven impact, barely affecting some hospitals, while crippling others. Although foreign medical graduates account for about 40% of the interns and residents citywide, the proportion in individual voluntary and municipal hospitals ranges from 7% to 100%. Foreign medical graduates amount to more than 50% of the housestaff -- interns and residents -- in 23 hospitals, and in 12 of these institutions, the proportion of foreign medical graduates is more than 75%.[9] Eight hospitals with strong affiliations to medical schools have been able to reduce their use of foreign medical graduates since 1978, but many municipal and small voluntary hospitals serving poor patients remain heavily dependent on the foreign graduates.

TABLE I:

DEPENDENCE ON FOREIGN MEDICAL GRADUATES IN NEW YORK CITY BY HOSPITAL AND INCOME OF CATCHMENT AREA FAMILIES

Hospital	Location	Catchment Area Families with income less than $5,000 a year
More than 75 Percent Foreign Medical Graduates		
Bronx-Lebanon*	Bronx	30-40%
Cumberland	Brooklyn	20-30%
Goldwater	Manhattan	less than 20%
Greenpoint	Brobklyn	more than 40%
Brooklyn-Jewish*	Brooklyn	more than 40%
Jewish Memorial*	Brooklyn	30-40%
Kingsbrook*	Brooklyn	more than 40%
Methodist*	Brooklyn	20-30%
St. Johns Esp.*	Brooklyn	more than 40%
Sydenham	Manhattan	20-30%
Catholic Medical Center*	Brooklyn	NA**
Flushing*	Queens	NA**
51-75% Foreign Medical Graduates		
Beekman*	Manhattan	more than 40%
Cabrini*	Manhattan	less than 20%
Coler	Manhattan	less than 20%
Coney Island	Brooklyn	20-30%
Elmhurst	Queens	NA**
Jamaica*	Queens	more than 40%
Veterans Administration	Bronx	NA**
Long Island College*	Brooklyn	20-30%
St. Vincent's*	Staten Island	20-30%
Lutheran*	Manhattan	30-40%
N.Y. Infirmary	Manhattan	less than 20%
26-50% Foreign Medical Graduates		
St. Luke's*	Manhattan	30-40%
Beth Israel*	Manhattan	less than 20%
Booth*	Queens	NA**
Brookdale*	Brooklyn	30-40%
Kings County/ Downstate	Brooklyn	30-40%
Harlem	Manhattan	20-30%
Staten Island*	Staten Island	20-30%
Metropolitan	Manhattan	more than 40%
Einstein*	Bronx	less than 20%
Long Island Jewish*	Queens	less than 20%
Maimonides*	Brooklyn	less than 20%
Less than 26% Foreign Medical Graduates		
Bellevue	Manhattan	less than 20%
Bronx Municipal	Bronx	less than 20%
Lenox Hill*	Manhattan	less than 20%
Mt. Sinai*	Manhattan	more than 40%
Montefiore*	Manhattan	less than 20%
New York University*	Manhattan	less than 20%
St. Vincent's*	Manhattan	30-40%
New York Hospital*	Manhattan	less than 20%
Misericordia*	Bronx	less than 20%
N.Y. Eye and Ear*	Manhattan	less than 20%
Presbyterian*	Manhattan	30-40%
Roosevelt*	Manhattan	less than 20%

Source: "Foreign Medical Graduates in Graduate Medical Education Programs in New York City Hospitals", New York State Health Planning Commission, 1979.

*Voluntary Hospitals
**NA = Not Available

V. SERVICE DELIVERY IMPLICATIONS BY BOROUGH AND SPECIALTY

The reduced pool of FMG's will cause the greatest problems in hospitals run by the New York City Health and Hospitals Corporation (HHC), which trains about 40% of the foreign graduates in the City.

Municipal health services in some boroughs will be more affected by the new immigration requirements than others. Brooklyn hospitals, with the oldest physical plants, are now the most reliant on foreign medical graduates, while certain Bronx hospitals with prestigious medical affiliations are the least dependent. North Central Bronx Hospital, for example, is a brand new institution affiliated with the renowned Montefiore Hospital. Bronx Municipal Hospital Center, despite its older facility, attracts American graduates through its affiliation with the Albert Einstein School of Medicine.

TABLE II:

SURVEY OF HEALTH AND HOSPITALS CORPORATION DEPENDENCE ON FOREIGN MEDICAL GRADUATES BY BOROUGH (1979)

Borough	Total Number House Staff	Total Number FMG	Percent
Brooklyn	937	547	58.4
Queens	470	171	36.4
Manhattan	1,023	321	31.4
Bronx	784	245	31.3
Total	3,214	1,284	39.9

Source: Unpublished housestaff survey, Health and Hospitals Corporation, 1979.

While foreign medical graduates enter all medical specialties, they have tended to emphasize areas of less interest to American graduates. More than 80% of the foreign medical graduates, for example, are in four primary care specialties -- medicine, general surgery, pediatrics, and obstetrics/gynecology -- and four non-primary care fields -- pathology, psychiatry, anesthesiology, and rehabilitative medicine. Foreign graduates now make up 93% of the Health and Hospitals Corporation's pediatricians in Brooklyn, and the new policy could leave the borough without any children's services in the municipal hospitals.

The shortage of anesthesiologists throughout the City is already so severe that Dr. Joseph Giuffrida, Chief of Service at Manhattan's Metropolitan Hospital, warns that at Metropolitan "the Department of Anesthesiology wishes to go on public record that it cannot take responsibility for the lack of proper patient care."[10]

The extent of HHC's dependence on foreign graduates is detailed by borough and specialty in the following tables:

TABLE III:

DEPENDENCE OF HEALTH AND HOSPITALS COROPORATION ON FOREIGN MEDICAL GRADUATES BY SPECIALTY AND BOROUGH (1979)

Borough	Specialty	# of House Staff	# of FMG	Percent
Brooklyn				
	Surgery	140	86	61.4
	Pediatrics	121	112	92.6
	Pathology	36	32	88.9
	Obs/Gyn	78	47	60.1
	Medicine	355	183	51.5
	Psychiatry	45	17	37.8
	Anesthesiology	16	14	87.5
Manhattan				
	Surgery	101	66	65.3
	Pediatrics	111	53	47.7
	Pathology	41	13	31.7
	Obs/Gyn	92	20	21.7
	Medicine	266	15	5.6
	Psychiatry	110	33	30.0
	Anesthesiology	49	33	67.3
	Rehab. Medicine	45	38	84.4
Queens				
	Surgery	34	8	23.5
	Pediatrics	62	24	38.7
	Pathology	21	20	95.2
	Obs/Gyn	21	3	14.2
	Medicine	146	28	19.2
	Psychiatry	72	36	50.0
	Anesthesiology	-	-	-
	Rehab. Medicine	17	14	82.3
Bronx				
	Surgery	69	18	26.0
	Pediatrics	112	25	22.3
	Pathology	17	6	35.3
	Obs/Gyn	49	22	44.8
	Medicine	203	58	28.5
	Psychiatry	66	14	21.2
	Anesthesiology	35	30	85.7
	Rehab. Medicine	18	16	88.8
	Specialty Totals	2,548	1,084	42.5

TABLE IV:

DEPENDENCE OF HEALTH AND HOSPITALS CORPORATION ON FOREIGN MEDICAL GRADUATES IN BRONX HOSPITALS (1979)

Hospital	Total # Staff	Total # FMG	%	Specialty	# House Staff	# FMG	%
Bronx Municipal	466	96	20.6	Surgery	41	0	0.0
				Pediatrics	54	3	5.6
				Pathology	13	4	30.8
				Obs/Gyn	24	3	12.5
				Medicine	89	2	2.2
				Psychiatry	47	2	4.3
				Anesthesiology	30	25	83.3
				Rehab. Medicine	13	11	84.6
Lincoln	176	135	76.7	Surgery	22	18	81.8
				Pediatrics	31	31	100.0
				Pathology	2	2	100.0
				Obs/Gyn	20	18	90.0
				Medicine	60	56	93.3
				Psychiatry	12	11	91.6
				Anesthesiology	-	-	-
				Rehab. Medicine	1	1	100.0
North Central	142	14	9.9	Surgery	6	0	0.0
				Pediatrics	27	1	3.7
				Pathology	2	0	0.0
				Obs/Gyn	5	1	20.0
				Medicine	54	0	0.0
				Psychiatry	7	1	14.3
				Anesthesiology	5	5	100.0
				Rehab. Medicine	4	4	100.0
TOTALS	784	245	31.3				

TABLE V:

DEPENDENCE OF HEALTH AND HOSPITALS CORPORATION ON FOREIGN MEDICAL GRADUATES IN BROOKLYN HOSPITALS (1979)

Hospital	Total # Staff	Total # FMG	%	Specialty	# House Staff	# FMG	%
Cumberland	172	145	84.3	Surgery	34	28	82.4
				Pediatrics	32	28	87.5
				Pathology	11	9	81.8
				Obs/Gyn	22	17	77.2
				Medicine	70	63	90.0
				Psychiatry	NA	NA	-
				Anesthesiology	NA	NA	-
Greenpoint	144	119	82.6	Surgery	26	22	84.6
				Pediatrics	36	32	88.9
				Pathology	-	-	-
				Obs/Gyn	22	18	81.8
				Medicine	48	36	75.0
				Psychiatry	-	-	-
				Anesthesiology	-	-	-
Kings County	538	221	41.1	Surgery	72	28	38.9
				Pediatrics	51	50	98.0
				Pathology	19	17	89.5
				Obs/Gyn	31	10	32.2
				Medicine	173	40	23.1
				Psychiatry	45	17	37.8
				Anesthesiology	16	14	87.5
Coney Island	83	62	74.7	Surgery	8	8	100.0
				Pediatrics	2	2	100.0
				Pathology	6	6	100.0
				Obs/Gyn	3	2	66.7
				Medicine	64	44	68.8
				Psychiatry	-	-	-
				Anesthesiology	-	-	-
TOTALS	937	547	58.4				

TABLE VI:

DEPENDENCE OF HEALTH AND HOSPITALS CORPORATION ON FOREIGN MEDICAL GRADUATES IN QUEENS HOSPITALS (1979)

Hospital	Total # Staff	Total # FMG	%	Specialty	# House Staff	# FMG	%
Queens	330	82	24.8	Surgery	34	8	23.5
				Pediatrics	45	8	17.8
				Pathology	12	11	91.7
				Obs/Gyn	21	3	14.3
				Medicine	78	6	7.7
				Psychiatry	42	7	16.7
				Anesthesiology	-	-	-
				Rehab. Medicine	1	1	100.0
Elmhurst	140	89	63.6	Surgery	-	-	-
				Pediatrics	17	16	94.1
				Pathology	9	9	100.0
				Obs/Gyn	-	-	-
				Medicine	68	22	32.3
				Psychiatry	30	29	96.6
				Anesthesiology	-	-	-
				Rehab. Medicine	16	13	81.2
TOTALS	470	171	36.4				

TABLE VII: DEPENDENCE OF HEALTH AND HOSPITALS CORPORATION ON FOREIGN MEDICAL GRADUATES IN MANHATTAN HOSPITALS (1979)

Hospital	Total #			Specialty	# House Staff	# FMG	%
	Staff	FMG	%				
Harlem	261	122	46.7	Surgery	74	50	67.6
				Pediatrics	26	23	88.5
				Pathology	9	9	100.0
				Obs/Gyn	38	16	42.1
				Medicine	84	2	2.4
				Psychiatry	23	18	78.3
				Anesthesiology	1	1	100.0
Metropolitan	222	92	41.4	Surgery	27	16	59.3
				Pediatrics	23	15	65.2
				Pathology	-	-	-
				Obs/Gyn	17	3	17.6
				Medicine	65	7	10.8
				Psychiatry	30	13	43.3
				Anesthesiology	15	15	100.0
				Rehab. Medicine	5	5	100.0
Bird S. Coler	18	12	66.7	Surgery	-	-	-
				Pediatrics	2	2	100.0
				Pathology	-	-	-
				Obs/Gyn	-	-	-
				Medicine	6	2	33.3
				Psychiatry	-	-	-
				Anesthesiology	-	-	-
				Rehab. Medicine	6	6	100.0
Bellevue	517	95	18.4	Surgery	NA	NA	-
				Pediatrics	60	13	21.7
				Pathology	32	4	12.5
				Obs/Gyn	37	1	2.7
				Medicine	111	4	3.6
				Psychiatry	57	2	3.5
				Anesthesiology	33	17	51.5
				Rehab. Medicine	34	27	79.4
TOTALS	1,018	321	31.5				

In sum, if the Department of Health and Human Services prediction of a two-thirds reduction of foreign medical graduates nationally holds true for New York City, the Health and Hospitals Corporation will lose more than 800 physicians by 1984 --one-half the HHC housestaff in pediatrics, child psychiatry, general surgery and obstetrics/gynecology. These loses will jeopardize the delivery of health services where the dependence on foreign medical graduates is most acute, especially at Cumberland, Greenpoint, Lincoln, Kings County, and Elmhurst hospitals.

Moreover, there is the strong possibility that HHC hospitals will lose more than the two-thirds reduction projected for the entire country. As the nationwide pool of foreign medical graduates shrinks, the competitive position of hospitals to recruit housestaff becomes more important. Financial problems and outdated facilities already put municipal hospitals at a disadvantage. Applications for internships and residencies at HHC hospitals dropped 8% between late 1977 and late 1978, and individual institutions heavily dependent on foreign medical graduates reported fall offs from 25% to 75%.[11] New York's difficulties in recruiting physicians only will be compounded by the immigration restrictions.

VI. HEALTH AND HOSPITALS CORPORATION MEDICAL PERSONNEL COSTS INCREASE

The reduction of foreign medical graduates will force the Health and Hospitals Corporation -- in the short run at least -- to replace foreign graduates with more costly attending physicians and physician extenders (non-physician providers such as nurse practitioners, who perform medical tasks under the supervision of a doctor).

Replacing lost housestaff will be expensive for the Health and Hospitals Corporation. Interns and residents are a bargain for teaching hospitals. In exchange for training, they routinely work 70 to 90 hours a week and are paid less than half the salary of an attending physician.

Replacement costs will rise each year from 1980 to 1985, as increasing numbers of foreign medical graduates are affected by the new law and the expiration of the waiver provision. In 1981, only first year housestaff will be affected by the restrictions; upper level positions will continue to be occupied by foreign medical graduates already in the United States. By 1985, all levels of housestaff will be affected, and the foreign medical graduate pool will have been greatly reduced.

If the FMG reduction begins to disrupt hospital training programs, upper-level interns and residents may decide to move to more stable institutions. This would further undermine the viability of entire departments, jeopardizing still more health services.

Analysis by the Council President's Office indicates that in the four primary care specialties alone -- pediatrics, obstetrics/gynecology, medicine and surgery -- replacement costs for foreign medical graduates in Health and Hospitals Corporation hospitals will be at least $4.4 million in 1981. All cost estimates in this report assume that 75% of the foreign medical graduates now filling the 204 entry level positions are replaced by physician extenders and attending physicians, and that HHC will actually be able to find replacement personnel.

In 1982, when first and second year housestaff are affected, costs will rise proportionately, because more attending physicians will be needed to compensate for the greater responsibilities of second year interns and residents. Total replacement costs for the primary fields: $9.9 million.

Primary care replacement will continue to escalate in succeeding years, reaching $15.4 million in 1983 and $21 million in 1984.*

All these figures are conservative and none take into account the additional expense of replacing the non-primary care specialists, nor doctors in voluntary hospitals. Since it was not clear how many personnel will have to be replaced in the non-primary care fields, the added costs of hiring housestaff in pathology, rehabilitative medicine, anesthesiology and psychiatry were not included in this report.

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*For an explanation of the cost methodology see Appendix

Nor do these estimates reflect added costs to state mental health hospitals which are also heavily dependent on foreign medical graduates. In the five state institutions based in New York City, nearly all psychiatric residents are FMG's. The Director of Medical Education at Kingsboro Psychiatric Center reports a severe recruitment problem already and predicts that "patient care will suffer in the future because we will not have enough physicians."

VII. RECOMMENDATIONS

A. Short Term Recommendation

Although the new FMG policy is certain to drive up expenses in City hospitals, several steps should be taken to minimize the additional costs.

In the short run, Congress must extend the phase-in period of the law from December 31, 1980 to December 31, 1985, allowing the federal government to continue granting waivers to avoid a "substantial disruption of health services."

The present waiver provision went into effect in 1978. Between 1978 and today, New York City has increasingly relied on waivers to fill housestaff positions in primary care, according to Magdalene Miranda, Chief of the International Education Program, Health Resources Administration, which administers the waiver program.

Waivers Approved

Year	National Totals	New York City Only
1978	18	9
1979	110	81
Jan. 1980	17	17
Feb. 1980	96 pending	95 pending

Extension of the waiver deadline would give the Health and Hospitals Corporation and many affected voluntary hospitals more time to prepare for the reduction of available foreign medical graduates. It must be pointed out that until recently, the hospital community in New York City -- including the Corporation -- had not used the time already allowed by the federal government to seek replacements for foreign graduates. As a result, Henry Foley of the federal Health Resources Administration expressed "concern that alternatives for meeting the future needs of the educational/service programs have not been adequately addressed" by the Corporation.[12]

Representatives of the Council President's Office, the Corporation and Chiefs of Service of the affected municipal hospitals have subsequently met with Dr. Foley to respond to his comments. The Corporation has made a commitment to present a working plan for seeking competent medical personnel to fill vacancies left by the shrinking pool of qualified foreign medical graduates. It is generally agreed that a suitable plan must be a part of, or a predicate to, the waiver application of any hospital, public or voluntary, if the waiver period is extended.

B. Long Term Recommendations

Extension of the waiver exemption until 1985 will, in and of itself, do nothing to solve the underlying problems created by the reduced availability of foreign medical graduates. Long term solutions must be found and implemented to insure the continued provision of essential medical services, particularly in the primary care specialties:

1. Coordinate length of foreign medical graduate's stay in United States with length of training program. The law as presently written imposes a two-year time limit on training (with an optional third year if requested by the foreign medical graduate's home country). After that, the physician must leave the United States, even if the training program has not been completed. Since this period is shorter than most approved residency programs, the attractiveness of American graduate medical education is greatly diminished.

Alien physicians who come to the United States for graduate medical education and who otherwise qualify for entry should be allowed to remain for a period equal to the length of their program. This would permit foreign medical graduates to return home with the appropriate skills. Medical care would not be compromised by shortages of upper-level resident physicians, created by the forced departure of foreign medical graduates after two years.

2. Include municipal and voluntary hospital training programs in National Health Service Corps service commitment. The National Health Service Corps program provides scholarships to medical students in return for a service commitment in medically-underserved areas. But current law bars these physicians from counting any portion of their training as interns or residents towards fulfillment of their service obligation, and also precludes any Corps service in municipal hospitals.

The law should be amended to allow participation in designated training programs in voluntary and municipal hospitals to fulfill the physician's service obligation. Programs should be designated only: (1) if they involve primary care specialties in medically underserved areas such as Brooklyn and (2) are in hospitals currently dependent on foreign medical graduates for the provision of care.

There are several advantages to this approach. First, the National Health Service Corps physicians would provide essential services to medically underserved communities while continuing their medical education. Since many physicians end up practicing medicine in the community where they are trained, this amendment will help retain doctors in underserved areas. Second, it would reduce the direct cost of the program to the Federal government since the trainee would be paid by the teaching hospital rather than Washington, D.C.

3. Intensify recruitment of United States medical graduates. In 1978, 1,132 of the more than 14,000 graduates of U.S. medical schools were from schools located in New York City. More than half the local graduates stayed in the City for their postgraduate training, but only 30 percent of these entered the municipal system.

Recruiting more United States medical graduates to fill housestaff positions formerly held by foreign medical graduates will not be easy. Attracting graduates means reversing the competitive disadvantage of HHC hospitals. The uncertainties created by municipal hospital closings, and well-publicized shortages of nurses, medical supplies and equipment make this unlikely for most HHC hospitals. The best opportunity is in Brooklyn, where the foreign medical graduate problem is the greatest.

A successful July 1981 opening of Woodhull Hospital in Brooklyn, coupled with the closing of aging and substandard Greenpoint and Cumberland Hospitals and a 170-bed reduction at overcrowded Kings County Hospital, should greatly improve the attractiveness of the Brooklyn housestaff training programs. Woodhull's new physical plant and its direct affiliation with Downstate Medical School hopefully will lead many more highly qualified applicants to apply for housestaff positions, despite Woodhull's obvious planning and design flaws in this age of austerity.

Opening a 640 bed hospital successfully is a complex process and depends on many interrelated actions taking place in concert. Without proper preparation, Woodhull is likely to open late or haphazardly, greatly diminishing its potential to recruit. To take full advantage of the recruiting opportunity presented by Woodhull, the Corporation must implement the innovative medical programs now planned for the facility.

4. Step-up recruitment of American-born foreign medical graduates. Enrollment in foreign medical schools has become increasingly attractive for Americans who want to study medicine and cannot get into U.S. schools. The American Association of Medical Colleges conservatively estimates there are 6,000 such students studying throughout the world.[13] Recruiting more U.S. graduates of foreign medical schools offers real potential for replacing foreign-born FMG's.

At present, about 7 percent of HHC housestaff positions are filled with American graduates of foreign medical schools.[14] Since many U.S. foreign medical graduates are from the New York metropolitan area, local hospitals can offer not only graduate education but also the opportunity to be near families and friends after many years away.

To enlist more of these students, the Corporation should develop outreach programs to attract the most qualified. "Fifth Pathway" programs must also be expanded. These programs were developed because several foreign medical schools -- particularly those in Mexico -- require an additional year or more of clinical training after completion of formal course work, but before the awarding of a medical degree. Students considered this unreasonable since the training was often conducted with little or no supervision. The "Fifth Pathway" permits a year of clinical training, under the supervision of an American medical school, to replace the required training in Mexico and other countries. Successful completion of this year allows entry into graduate training programs, without the necessity of certification by the Educational Commission for Foreign Medical Graduates or actual possession of the medical degree.

5. Reduce surplus housestaff positions. Some foreign medical graduates are filling positions in specialties that exist more for teaching purposes than for patient needs. Likewise, some specialty services now offered in a number of municipal and voluntary hospitals could be consolidated and regionalized, allowing a more efficient use of a reduced number of physicians.

The Corporation should undertake a program-by-program analysis to identify housestaff positions that can be eliminated without adversely affecting the delivery of services to reduce the number of graduate physicians needed.

In reality, any strategy to reduce dependence on foreign physicians must employ a combination of these options in order to succeed. For too long, HHC has not had to compete for quality personnel because of the ready availability of FMG's. That time has passed. A plan -- with firm targets for implementation -- must now be devised to replace these physicians, especially in the primary care specialties.

VIII. CONCLUSION

The previous pages document the critical doctor shortage New York City must confront over the next few years, particularly in municipal and voluntary hospitals in inner-city neighborhoods. This report makes specific short and long range recommendations to help the City cope with what could be a serious health care delivery crisis.

But lost in this debate is the larger issue of maldistribution -- by specialty and geography -- of physicians trained here in the United States.

With educational priorities in American medical schools stressing diagnosis and treatment of exotic illnesses over day-to-day delivery of basic medical services, it is not surprising that many medical students opt for such over-subscribed specialties as neurosurgery and tropical medicine, rather than such badly needed primary care fields as family practice and pediatrics.

And, lured by the financial rewards offered by affluent urban areas and suburbs, not enough physicians elect to serve in the inner-city. In most areas of the Bronx, for example, one doctor is available for every 10,000 people, as contrasted with a statewide ratio of one doctor for every 405 people. Residents of poor neighborhoods depend on hospital outpatient and emergency room service for primary care. As the Chief of Pediatrics at Greenpoint Hospital put it: "Interns and residents are the family doctors of the poor." And in many municipal hospitals today, that intern or resident is likely to be foreign-born.

One might say that the fact there is a need for this study and its recommendations is a sad commentary on the American medical profession today. For stop-gap legislation regarding the FMG cutoff is not the answer. Redistributing medical personnel, so that all specialties and regions are sufficiently covered and access to health care is assured for the poor and working class, depends on reordering the priorities of American medical education. It rests with health policy-makers, both public and private, and physicians themselves to develop a coherent medical manpower policy to accomplish these goals.

APPENDIX

COST METHODOLOGY FOR REPLACING FOREIGN MEDICAL GRADUATE HOUSESTAFF WITH ATTENDING PHYSICIANS AND PHYSICIAN EXTENDERS

A number of assumptions were used to estimate the replacement costs should unfilled housestaff positions result from the full implementation of P.L. 94-84. These assumptions were made conservatively due to the inherent uncertainty of forecasting the Corporation's ability to recruit from the reduced pool of FMG's, as well as the wide variation in individual training programs at HHC hospitals. Since the delivery of necessary health services -- not lost educational opportunities -- are the major concern, only the costs of replacing direct patient care activities were considered.

Data as to the number of foreign medical graduates in entry and intermediate level housestaff positions were obtained from the 1978 Health and Hospitals Corporation Housestaff Survey and Findings, since the 1979 survey was not categorized by year of training. No significant changes in personnel, however, have occurred between 1978 and 1979.

In 1978, FMG's occupied 132 of the 277 entry level positions in the non-primary care specialties (pathology, anesthesiology, psychiatry, and rehabilitative medicine) and 480 of the 1,064 positions at all levels. No replacement costs were calculated for these specialties since a large portion of physician time is spent on education-related activities, not patient care. (It is clear, however, for the same reasons outlined below, that replacement costs for patient care activities performed by these specialists will be higher.)

In the primary care specialties (pediatrics, obstetrics/gynecology, medicine and surgery), foreign medical graduates occupied 204 of the 536 entry level positions and 642 of the 1,551 positions at all levels. Replacement costs were calculated for these specialties only -- because most physician time is spent on direct patient care.

A. Assumptions and Methodology

1. Entry level housestaff (PGY-I) work an average of 80 hours per week. Ten percent of this time was discounted as educational so that direct services were considered to be provided 72 hours per week.

2. Intermediate level housestaff (PGY-II and III) work an average of 72 hours per week. Ten percent of this time was discounted as educational so that direct services were considered to be provided 65 hours per week.

3. It was assumed that all service hours are necessary for patient care.

4. Replacement providers (physician extenders and attending physicians) work a standard 40-hour week.

5. Entry level housestaff (PGY-I) could be replaced on a one-to-one basis by physician extenders. Supervision by attending physicians, equal to one attending for every ten physician extenders, would be necessary to assure adequate quality of care.

6. Intermediate level housestaff (PGY-II and III) could be replaced by 0.5 physician extender and 0.5 attending physician. (This probably understates physicians duties, underestimating additional costs.)

7. Physician extenders were considered to be salaried at $25,000 a year ($20,000 plus 25 percent fringe benefits). Attending physicians were considered to be salaried at $50,000 a year ($40,000 plus 25 percent fringe benefits). Housestaff were considered to be salaried at $25,000 a year ($20,000 plus 25% fringe benefits). While current starting salaries for housestaff and physician extenders are in fact lower than those cited above, these averages include adjustments for seniority and inflation over the next three years.

B. Individual Housestaff Replacement Costs

1. For each unfilled first-year housestaff position, the additional replacement cost is $29,000

1.80 physician extenders X $25,000 = $45,000
.18 attending physicians X $50,000 = $ 9,000
$54,000

($54,000 - $25,000 unpaid housestaff salary = $29,000)

2. For each unfilled intermediate level (PGY-II and III) housestaff position, the additional replacement cost is $35,900

0.812 physician extenders X $25,000 = $20,300
0.812 attending physicians X $50,000 = $40,600
$60,900

($60,900-$25,000 unpaid housestaff salary = $35,900)

C. Estimated Additional Costs-By Year

1981

In 1981, only first year housestaff will be affected by the elimination of the waiver since upper level positions are filled with foreign medical graduates already admitted to the United States under the old restrictions. Assuming 75 percent of the 204 entry level positions will have to be replaced by physician extenders and supervising attending physicians, the additional cost will be $4.4 million.

153 first year positions X $29,000 replacement cost per position = $4.4 million

1982

In 1982, both first and second year housestaff will be affected by the elimination of the waiver. Third year housestaff positions will still be filled with foreign medical graduates admitted to the United States under the old restrictions. Assuming all first year housestaff are promoted and assuming 75% of the first and second year positions will have to be replaced, the additional cost will be $9.9 million.

153 first year positions X $29,000 replacement cost per position = $4.4 million

153 second year position X $35,900 replacement cost per position = $5.5 million

1983

In 1983, first, second and third year housestaff will be affected by the elimination of the waiver. Assuming all first and second year housestaff are promoted, and assuming that only 75% of the third year positions will have to be replaced, the additional cost will be $15.4 million.

153 first year positions X $29,000 replacement cost per position = $4.4 million

153 second year positions X $35,900 replacement cost per position = $5.5 million

153 third year positions X $35,900 replacement cost per position = $5.5 million

1984

In 1984, first, second, third and fourth year housestaff will be affected by elimination of the waiver. All housestaff are promoted, and assuming only 75% of the fourth year portions will have to be replaced, the actual cost will be $21 million in 1984.

153 first year positions X $35,900 replacement cost per position = $4.4 million

153 second year positions X $35,900 replacement cost per position = $5.5 million

153 third year positions X $35,900 replacement cost per position = $5.5 million

153 fourth year positions X $35,900 replacement cost per position = $5.5 million

FOOTNOTES

1. Update Report on Foreign Medical Graduates in the United States, Department of Health, Education, and Welfare, 1977, Table IV.
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3. "Foreign Medical Graduates and the Issue of Substantial Disruption of Medical Services", New England Journal of Medicine, 299: 745-751 (1978).
4. "Foreign Medical Graduates in Graduate Medical Education Programs in New York City Hospitals", New York State Health Planning Commission (1979).
5. Title VI, P.L. 94-484, October 12, 1976, 90 Stat. 2243, as amended by P.L. 95-83, August 1, 1977, 91 Stat. 383.
6. *Ibid.*
7. New York State Health Planning Commission, *op. cit.*
8. *Ibid.*
9. *Ibid.*
10. July 24, 1979 memorandum from Dr. Joseph E. Guiffrida to Dr. Camille Mallouh, President, Medical Board, Metropolitan Hospital.
11. New York State Health Planning Commission, *op. cit.*
12. July, 1979 letter from Henry Foley, Ph.D., Administrator, Health Resources Administration, to Mr. Jack Koretsky, Executive Vice President, Health and Hospitals Corporation

13. "Career Choice and Performance on State Licensing Examinations of 'Fifth Pathway' Students", New England Journal of Medicine, 299: 227-250 (1978).

14. Health and Hospitals Corporation Housestaff Study and Findings, published May, 1978.

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March 25, 1980

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Subcommittee on Health and Environment
Rayburn House Office Building
Washington, D.C. 20515

Dear Mr. Waxman:

The American Dental Hygienists' Association wishes to go on record with you and members of the House Commerce Health Subcommittee as supporting the provisions of your new health manpower bill, the "Health Professions Educational Assistance and Nurse Training Amendments of 1980" (H.R. 6802), introduced in the House of Representatives on March 12.

This letter will offer comments and suggestions on H.R. 6802 specifically and also include comments on the Administration's health manpower bill and two bills introduced in the Senate by Senators Schweiker and Kennedy. Comments on the Administration, Schweiker and Kennedy bills are included on an enclosed record statement recently transmitted to the Senate Human Resources Subcommittee on Health.

Renewal of the legislative authority for the Health Professions Educational Assistance Act of 1976 (P.L. 94-484) is one of the highest priorities among the Association's 1980 legislative goals. Accordingly, the Association commends you and your cosponsors in the House of Representatives for taking the initiative to continue federal support for the health professions education and training programs into the 1980's.

On the basis of informal estimates, ADHA has determined that the federal government has already invested over $7 billion in providing assistance to health professions schools and training centers since Congress passed the first health manpower bill in 1963 (P.L. 88-129) and the Allied Health Professions Personnel Training Act of 1966 (P.L. 89-751). Thus, for more than sixteen years, Congress has demonstrated its belief and conviction that health profession and allied health professions schools and training centers are an important national resource needed to assure that health and allied health professionals are available in adequate supply to provide high quality health care to as many of the nation's citizens as possible.

The Association believes that the quid pro quo of the federal/private sector partnership on health manpower programs and issues, through the years of such legislation, has been effective and mutually productive and beneficial. Some of the national goals inititally determined have already been attained; however, there are still unmet and unresolved goals to be addressed, such as, improving access to and availability of health care to unreached and special population groups.

The Assocaition applauds your efforts to continue to modify the current health manpower programs in accordance with envisioned needs and to extend support for the educational institutions and agencies of the health professions. Our comments on H.R. 6802 follow, as enclosure #1. As noted previously, more extensive thoughts and reflections on health manpower issues transmitted to the Senate Human Resources Health Subcommites are also included as enclosure #2.

We respectfully request that this letter, with its enclosures, be included on the record of the March, 1980 Subcommittee hearings.

Very sincerely,

Jeri Yunker

Jeri Yunker, President
American Dental Hygienists' Association

JLY/cd
enclosures

cc: Members of the House Commerce Subcommittee on Health

AMERICAN DENTAL HYGIENISTS' ASSOCIATION

Comments on Health Professions Educational Assistance and Nurse Training Amendments of 1980 (H.R. 6802)

"Title I - National Health Service Corps Programs"

Section 102. Revision of National Health Service Corps Scholarship Program

Comments

The Association strongly urges the subcommittee to consider students in dental hygiene baccalaureate and master's degree programs as eligible to apply for NHSC scholarships. According to the *Federal Register*'s notice of March 12, 1980, page 16012, baccalaureate and master's degree nursing students have been added to the list of eligible candidates to receive scholarships (sect. 751 of the PHS Act) and, from the standpoint of the dental care delivery system, similarly credentialed dental hygienists should be considered to assure an adequate supply of dental professionals.

"Title II - Health Professions Programs Under Title VII"

Part C - Section 770. Institutional Support Grants

Comments

The Association's views on providing institutional support grants for dental schools are stated at length in Enclosure 2 of the cover letter. As noted in our statement transmitted to the Senate Human Resources Subcommittee, ADHA is opposed to the termination of institutional educational assistance grants at this time, as proposed in H.R. 6800 and S.2144. The authorization levels recommended in Section 770 (d) (3) in H.R. 6802 for FY 1981-1983 appear to represent reasonable appropriations' targets for the dental educational institutions to maintain the quality of their curriculums and faculties as established under previous health manpower legislation. Also, the Association concurs with the sponsors of H.R. 6802 that annual enrollment increases, as a means test for eligibility for federal assistance, are no longer necessary.

Part D - Section 217 Project Grants and Contracts; Physician Assistants and Dental Auxiliaries

Comments

The Association has supported the inclusion of EFDA grants in previous health manpower laws and firmly believes that this title of a new law should be retained as it is in H.R. 6802. However, in view of the Comptroller General's Report on "Increased Use of Expanded Function Dental Auxiliaries Would Benefit Consumers, Dentists and Tax Payers", March 71, 1980, the Subcommittee may wish to consider the necessity for establishing a separate authorization for EFDA training. If Congress determines that the Comptroller General's recommendations should be implemented within the federally funded dental care delivery system, EFDA training programs will become significantly more important in the overall effort to improve the efficiency of the dental component of the nation's health care delivery system. The Association recommends that authorizations for EFDA training programs be as follows: $5,000,000 for the fiscal year ending September 30, 1981; $6,000,000 for the fiscal year ending September 30, 1982; and $7,000,000 for the fiscal year ending September 30, 1983. In addition, the Association urges that the EFDA grants program be funded separately from the Physician Assistants grants program to more clearly reflect the intent of Congress.

Section 794. Midcareer Training and Education

Comments

The Association supports this section of H.R. 6802 which it recognizes as an innovative health manpower concept that logically arises from previous health manpower program initiatives. If implemented, the Association urges the Subcommittee to include allied health training centers as possible sites in which advanced training in health systems financial management and health care strategies could be offered.

Section 794 C. Grants to Departments of Preventive or Community Medicine or Dentistry

Comments

The Association supports the intent of the sponsors of H.R. 6802 to provide incentives for dental and medical schools to establish departments of preventive dentistry and medicine to coordinate pre-doctoral and post-doctoral courses. While many of the schools have already established preventive and community health departments in their curriculums, the coordination and integration of preventive approaches to health care do need to be interwoven with instruction offered in other major departments. Since dental hygiene education is primarily prevention oriented, dental hygiene departments of dental schools will be an important resource for the dental educators to utilize in designing new programs to qualify for assistance under Section 794 C.

The American Dental Hygienists' Association supports the proposal to establish preventive and community dental health departments in dental schools and recommends that the authorizations for this special project program outlined in H.R. 6802 be increased to $4,000,000, $5,000,000, and $6,000,000 in FY 1981, 1982 and 1983. It is further recommended that these sums be divided equally between dental and medical schools on a first-come, first-served basis.

Part F - Allied Health Personnel. Section 235, Project Grants and Section 236, Traineeships

Comments

The Association, as one of the allied health professions designated in the original Allied Health Professions Personnel Training Act of

1966 (P.L. 89-751), strongly supports the continued inclusion of an allied health authority in the amendments to P.L. 94-484. Despite efforts of the Executive Branch in recent years to terminate this program, ADHA does not believe that the need for continued support of allied health training centers and programs has diminished. Among the health manpower proposals now being considered in Congress, only H.R. 6800, the Administration bill, does not recognize the necessity of providing continued support for allied health educational institutions. We urge the House Commerce Subcommittee on Health to hold firm in its intention to support allied health education and training at least at the levels proposed in Sections 235 and 236 of H.R. 6802. While this level of support does not seem to be adequate to meet the needs for federal support of the schools of allied health, the Association recognizes the severity of pressures currently to stay within the Congressional budgetary limits which are still under consideration.

aota

The American Occupational Therapy Association, Inc.

March 25, 1980

The Honorable Henry A. Waxman, Chairman
Subcommittee on Health & The Environment
Committee on Interstate and Foreign Commerce
2424 Rayburn House Office Building
Washington, D.C. 20515

Dear Mr. Chairman:

On behalf of the American Occupational Therapy Association (AOTA) and its 29,000 members, I welcome the opportunity to offer testimony in conjunction with your hearings on the reauthorization of the health manpower legislation. I would request that this letter and the accompanying statement be incorporated into the record of these hearings.

Occupational therapists are among those health professionals traditionally categorized in Title VII of the Public Health Service Act as "allied health". The "allied health" professionals currently constitute a sizable portion of the total 5 million person health care workforce, 20 percent by conservative estimates and well over 50 percent by others. Despite this substantial dependence of the health care delivery system on "allied health" personnel, the Federal government has consistently failed to provide adequate support for "allied health" education. From 1965 - 1976 the Federal government spent $4.2 billion on the education of health professionals. Of this amount, only $183 million, or 4 percent of the total, supported "allied health" programs. The inequity of these allocations is patently obvious. More alarming, however, is the fact that without increased government assistance "allied health" educational programs may soon no longer be able to meet the rising demand for more "allied health" practitioners. As the delivery system begins to experience the effect of "allied health" personnel shortages, the real impact of government neglect of "allied health" education will be demonstrated.

Recent studies, published by the Department of Health, Education and Welfare and the Department of Labor, indicate the rising demand for more "allied health" personnel. Prior to these reports, there existed a widely-held assumption there were no personnel shortages among health professionals. The only problem was maldistribution. Usually studies of physician supply and demand were cited as support for these conclusions. The conclusions were equally, and rather glibly, applied to all health professions, including "allied health" professionals, on the false assumption that what applied for physicians must also hold true for other health professionals. Data to support this sweeping application was never presented.

With regard to occupational therapists, one would be hard-pressed to find such data, since none exists. On the contrary, as I describe in my statement, current evidence indicates that there are now severe shortages of occupational therapists and that these shortages will continue throughout the present decade. I seriously urge that this information be given careful consideration and attention, as you develop new legislation in this area.

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I would also point out that the personnel shortages among occupational therapists are directly related to the educational system. At the present time, occupational therapy educational programs are forced to turn away between one-third and one-half of the qualified students who apply. These students cannot be accepted because there are neither sufficient numbers of faculty nor adequate space to provide for their education, and because the spiraling cost of a college education prohibits many interested and competent young people from pursuing a career in occupational therapy. There is, therefore, an urgent need for increased Federal assistance for faculty development, space improvements, and student support. This need certainly exists for occupational therapists, and I would suspect that it would also apply to many other of the "allied health" professions.

Occupational therapists, together with other "allied health" professionals, play a crucial role in the delivery of health care services. Their efforts are directed toward increasing the independence of individuals with physical, psychological, or developmental disabilities. An occupational therapist's success with a patient means, among other things, that the individual will no longer be dependent on continuing costly care. In some instances, it further means that the individual will be able to return to wage earning employment. In both situations, important subsidiary benefits of the occupational therapist's services are frequently the cost savings effected for the total health care system and the additional revenue production resulting from renewed employment.

I would also point out, moreover, that when the Federal government supports the education of an occupational therapist, it is not contributing to the development of a health professional who will one day fall into the upper tax brackets. At the present time, the average annual salary for occupational therapists is approximately $15,000. The top brackets for supervisory occupational therapy personnel are between $21,000 and $24,000. Only 5 percent of the working profession falls into this top category. Support for occupational therapy education, then, could hardly be subject to the complaint that the government is unnecessarily subsidizing a wealthy profession.

As you and your Subcommittee go about the task of developing new health manpower legislation, Mr. Chairman, I strongly urge you to provide appropriate and adequate provision for the education of occupational therapists and other "allied health" professionals. The continuation of their important contributions to the provision of quality and cost-effective health care depends heavily upon the Federal government's support of their educational programs. Let your legislation ensure that this support is forthcoming.

In presenting this testimony, I also express my agreement with, and support for, the views expressed by the American Society of Allied Health Professions and the Coalition of Independent Health Professions.

Sincerely,

James J. Garibaldi
Executive Director

aota
The American Occupational Therapy Association, Inc.

STATEMENT

OF THE

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

ON

LEGISLATION RELATED TO THE

EDUCATION OF HEALTH PROFESSIONALS
(TITLE VII OF THE PUBLIC HEALTH SERVICE ACT)

SUBMITTED TO

SUBCOMMITTEE ON HEALTH & THE ENVIRONMENT

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

U. S. HOUSE OF REPRESENTATIVES

MARCH 25, 1980

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For over 60 years the American Occupational Therapy Association (AOTA) has represented health professionals who specialize in increasing the independent functioning and productivity of people of all ages who are physically, psychologically, or developmentally disabled. Occupational therapists work in a wide variety of settings using rehabilitation techniques to reduce pathology or impairment and help their clients achieve a maximal level of independence. Occupational therapists are committed to the belief that a health system which provides the best medical intervention in the world to save a life is incomplete if it does not include services to help ensure that the life which has been saved will be meaningful and productive.

Throughout its history, occupational therapy has been concerned with the prevention of disability. Therapists have traditionally concentrated in large measure on the healthy factors of the people with whom they work. Occupational therapists attempt to mobilize areas of "wellness" in the individual or society as a primary means of creating or maintaining good health. Their orientation is towards treatment of the whole person; their concern is to help the person develop awareness of the parts of his being which are well.

Occupational therapists believe that society has a moral obligation to provide comprehensive services to ensure that an individual's right to live with dignity, and to find meaning and satisfaction in living, is maintained.

In order to fulfill this obligation, society must, among other things, provide that sufficient numbers of qualified health professionals are available to serve its members. Occupational therapists are constantly made aware of what can happen when proper and timely treatment is not available. Unnecessary and lengthy stays in hospitals and nursing homes, forms of patient regression which require a return to more intensive care, rapid progression of a disease or debilitating condition which could have been prevented, all are examples of what can occur when no qualified person is available to provide needed treatment.

It is for this reason, then, that the American Occupational Therapy Association watches, with great concern, Congress' rewriting of the health manpower legislation. There is an increasing need for more occupational therapists. This need stems, in some part, from the establishment of Federal programs which mandate the services of occupational therapists or create the expectation that these services will be available if needed. The AOTA, therefore, looks to the Congress and the Federal government for assistance in assuring that competent occupational therapists will be educated and trained.

A review of the present personnel situation in the field of occupational therapy reveals existing shortages, increasing demand for more therapists, and an inability of the current educational system to produce sufficient numbers of therapists to meet either present or future demands. The remainder of this statement will address the specific data supporting this general overview and include recommendations for Federal legislative action.

Occupational Therapy: Supply and Demand

In recent years data collected from a variety of diverse sources clearly indicates that the current supply of occupational therapists fails to meet existing demand.

- Critical shortages of occupational therapists now exist in long-term care facilities. The 1975 "Long-Term Care Facility Improvement Study" of the Department of Health, Education and Welfare (DHEW) reported that 35 percent of the people in nursing homes need occupational therapy services and only 10 percent are receiving them. Moreover, a 1977 DHEW survey of nursing homes reported that 23 percent of the full-time occupational therapists positions were vacant.

- The Bureau for the Education of the Handicapped (DHEW) reports that a 1978 survey of state school systems showed that 1,700 occupational therapists were employed during Fiscal Year 1978 and that 2,400 occupational therapists would be needed for Fiscal Year 1979. This represents an increase of approximately 40 percent.
- Three of the nine state-operated MEDIHC (Military Experience Directed Into Health Careers) programs, which place "allied health" personnel in shortage areas and occupations, listed occupational therapy as a shortage occupation in their states in 1978.
- A 1979 survey of state occupational therapy associations, conducted by the American Occupational Therapy Association, indicates that in 58 percent of the states, local job placement services reported that there were more jobs than available personnel. A number of state-operated manpower programs have found the same situation. The State of Maryland, for example, reports that 35 out of 100 budgeted positions in the State Department of Health and Mental Hygiene are currently vacant.

Future projections, moreover, reveal that this demand will continue to increase at an even more rapid rate.

- In May, 1980 the Bureau of Labor Statistics (BLS) of the Department of Labor (DOL) will publish projections of growth for different occupations in "Occupational Projections and Training Data" (Bulletin 2058). BLS projects that over the next ten years there will be an average of 2,500 openings for occupational therapists each year, consisting of 1,300 new and 1,200 replacement openings.

This represents a 100 percent increase in demand for occupational therapists, a greater increase than for any other occupation or profession studied. As noted below, the capabilities of the present educational system fall far short of meeting this increased demand.

The recently published "Report on Allied Health Personnel" (DHEW, 1980), also identifies several other factors that "will probably cause the demand for occupational therapy personnel to increase in the future." Cited among these factors were the following:

"1) An increasing proportion of the population is reaching 65 years of age. The impact of chronic disabling medical ailments such as arthritis and stroke, therefore, will create a greater demand for occupational therapy services.

2) The passage of P.L. 94-142, the Education for All Handicapped Children Act of 1975, will undoubtedly increase the demand for occupational therapy personnel. This Act requires each state to ensure that a "free and appropriate education" is available to all handicapped children between the ages of 3 and 18 by September 1, 1978, and to such children between the ages of 3 and 21 by September 1, 1980.

3) Expansion of programs under the Rehabilitation, Comprehensive Services and Developmental Disabilities Amendments of 1978 (P.L. 95-602) will no doubt further increase the demand for occupational therapists. These amendments changed the definition of developmental disabilities from a short list of diagnoses to a functional definition. Title III, involving the Comprehensive Services for Independent Living Program, provides for the payment

> of services such as occupational therapy to those clients who can, through these services, increase their level of independence, even though they have no vocational potential or goal."

In the context of all these indicators of a present and continually increasing demand for occupational therapists, it should be noted that over the past decade the employment rate of occupational therapists has remained fairly constant -- about 78 to 80 percent -- while the numbers of therapists have increased at a rate of approximately 10 percent per year. Although each year there are more occupational therapists, there is also more than sufficient demand to absorb the increased numbers. The vast majority of the unemployed, moreover, are those who have retired or chosen to leave the work force for personal reasons, e.g., to remain at home during their children's early years. This latter characteristic could be expected in a profession, 95 percent of which is made up of women.

This increasing demand for occupational therapists, moreover, has gradually outstripped the capacities of the educational system, as a review of this system will indicate.

Occupational Therapy Educational System

Occupational therapy educational programs exist in 55 colleges and universities throughout the country. All of these programs are accredited jointly by the American Medical Association and the American Occupational Therapy Association. This accreditation system has operated since 1934.

Occupational therapists are required to complete either a four-year baccalaureate degree program, or a two-year certificate program or a two-year master's degree program following achievement of a baccalaureate degree in another field.

Six to nine months of supervised clinical experience follows completion of the academic preparation. The occupational therapist must then pass the national Certification Examination for Occupational Therapist, Registered.

Occupational therapy assistants must complete a two-year post-secondary course of study in a program approved by the American Occupational Therapy Association, undergo six to nine months of supervised clinical experience, and pass the national Certification Examination for Certified Occupational Therapy Assistants. There are 43 approved assistant level programs in colleges and junior colleges throughout the country.

A Career Mobility Program also exists for Certified Occupational Therapy Assistants who wish to become Occupational Therapists, Registered without completing the full Occupational Therapist, Registered academic program. The requirements of this program are:

- four years of employment as a Certified Occupational Therapy Assistant, six to nine months of supervised clinical experience at the Occupational Therapist, Registered level, and
- successful completion of the national Certification Examination for Occupational Therapist, Registered.

Beyond the entry level to the profession, there are also 16 master's and two Ph.D. programs in occupational therapy.

Occupational therapists and occupational therapy assistants are certified by the American Occupational Therapy Association. This national certification system, which was begun in 1934, is the only certification system for occupational therapists and assistants. Licensure laws governing the practice of occupational therapy have been enacted in 14 states, the District of Columbia, and Puerto Rico. All of these laws incorporate the same educational, clinical experience, and examination requirements as make up the AOTA certification system.

As noted above, over the past ten years the occupational therapy educational system has been somewhat capable of keeping pace with the growing demand for occupational therapists' services, although not to the point where current shortages could be eliminated. In recent years, however, the inability of the system to match the rapidly increasing demand has become readily apparent. Given the projections for the future, moreover, it is quite clear that unless the system is substantially expanded, the demand for occupational therapists will never be met.

As was cited above, the Bureau of Labor Statistics (BLS) projects 2,500 openings for occupational therapists each year through 1990. Under present conditions, the occupational therapy educational system provides to the work force approximately 1,700 new therapists each year, thereby leaving a shortage of 800 therapists, about 50 percent, per year.

By 1990, therefore, a shortage of close to 8,000 occupational therapists can reasonably be expected. This shortage could only be offset if the educational system were to grow at a rate similar to that experienced in the early 1970's. In fact, however, the growth rate of this system over the past several years has been zero.

The basic needs of the occupational therapy educational system, which must be met to remedy the current and future supply problems, can easily be identified. At the present time, close to 50 percent of the qualified applicants for admission to occupational therapy programs must be rejected because there is neither sufficient faculty nor adequate space to carry out the educational process. A secondary reason for the failure to educate more qualified therapists relates to the high cost of post-secondary and graduate education.

Over the past four years, the numbers of faculty in occupational therapy education programs has remained constant. Over the last five years student enrollments in these programs have increased by only 4.2 percent. Since 1976, only six new educational programs have been opened. Existing occupational therapy programs have reached saturation, with the numbers of graduates leveling off at approximately 1900 for each of the last several years.

All of this evidence clearly indicates that if the occupational therapy educational system is not expanded, the current gap between supply and demand will widen dramatically. The educational system holds the key to resolving this supply problem. If support can be furnished to increase faculty to provide more adequate space, to assist with student tuition and other costs, and to aid in the development of new programs, then sufficient numbers of qualified occupational therapists can be prepared to meet the rising demand for service. Occupational therapists, and other "allied health" professionals need Federal assistance for their efforts to rectify these current and future shortages. The new manpower legislation now being developed must demonstrate the government's committment in this area.

Legislative Recommendations

Although the Federal government cannot be expected to assume full responsibility for the education of health professionals, it can be expected to provide assistance to a degree proportionate to the contributions made by these professionals in carrying out Federal policies directed towards ensuring proper health care of the nation's citizens. The Federal government has established a wide variety of programs which are intended to make necessary health care services available. Some of these programs, such as those established under the Rehabilitation Act, the Older Americans Act, the Maternal and Child Health and Crippled Childrens' Services Act or the Mental Retardation Facilities and Community Mental Health Centers Construction Act establish mechanisms through which direct services can be provided. Other initiatives, such as that found in the Education of All Handicapped Children Act, mandate that states ensure that specific services are provided to specific populations. While still others, such as Medicare, offer a health insurance program directed primarily towards assisting older Americans in the payment of health care costs. All of these Federal initiatives directly create requirements for, or expectations of, the provision of health care services.

In light of these national initiatives, it would be irresponsible for the Federal government to reduce its committment to the education of the health professionals needed to provide the services covered under these programs. Enactment of the Education of All Handicapped Children Act, for example, represented a significant and praiseworthy step towards equalizing the nation's treatment of handicapped children. This Act requires that, if a child needs occupational therapy or physical therapy in order to benefit from a special education program, this therapy must be provided. The legal right to the service, however, is of questionable value, if no therapist is available to provide treatment. The Federal government must not just mandate services, it must also provide support to ensure that qualified people are available to serve.

Federal government support for the education of health professionals, moreover, must also be more equally distributed among the various professions than it has been in the past. It has been reported by the National Commission of Allied Health Education that $4.2 billion was appropriated by the Federal government for health professionals education between 1965 and 1976. Only $183 million, or 4 percent, of this amount was allocated to "allied health" education. Yet the "allied health" professions, as estimated most conservatively by DHEW, constitute over 20 percent of the entire health care workforce. Federal support for "allied health" education has consistently failed to match the contributions made by these professionals to the health care of the American people.

At a time when rising health care costs are a major concern, Congress might also well consider the cost-effective aspects of increased support for "allied health" professionals. These professionals regularly provide services which reduce or eliminate the need for costly institutional care. The timely provision of their services hastens patient recovery and reduces the potential for recurring disability. "Allied health" care frequently enables individuals to return more quickly to revenue-producing employment. The professionals providing these cost-saving services, moreover, are not high income wage earners. The average annual salary of an occupational therapist, for example, is approximatley $15,000. Support for "allied health" could hardly be classified as an unnecessary government subsidy of wealthy professionals, while at the same time it could very accurately be described as a most effective cost containment measure.

In light of these considerations, the American Occupatiorial Therapy Association urges a strong Federal committment to "allied health" education and offers the following recommendations relative to the legislation now being developed:

- include provisions as now contained in Sections 796, 797 and 798 of the Public Health Service Act;
- increase authorizations in existing Section 797 to $10,000,000 for Fiscal Year 1981 with increases of 20 percent per year for each successive year;
- increase authorizations in existing Section 798 to $5,000,000 for Fiscal Year 1981 with increases of 20 percent per year for each successive year;
- incorporate into the appropriate sections (for example, Section 708 of the current law if retained) provisions requiring establishment of programs to collect data on the outcome of treatment by "allied health" professionals and the impact on the total cost of health care delivery;
- incorporate into appropriate sections (for example, current Section 708) provisions requiring establishment of programs to investigate the need for capital support of "allied health" educational and training facilities with the stipulation that an authorization of $25,000,000 be set aside for appropriation

should the determination be made, prior to expiration of the legislation now being developed, that such need exists;

- establish a new section to provide institutional grant and individual loan assistance covering educational expenses of "allied health" students at the basic educational level, with emphasis noted that funds should be allocated with priority to those professions where demonstrated shortages are greatest, and establish authorizations of $20,000,000 for Fiscal Year 1981 and 20 percent per year increase in each successive year;
- establish a new section which would provide incentive scholarships for preparing faculty for "allied health" schools and include specific "pay-back" provisions requiring 2 to 4 years of teaching in designated schools where faculty shortages exist; and establish an authorization of $10,000,000 for Fiscal Year 1981, $12,500,000 for Fiscal Year 1982, and $16,000,000 for Fiscal Year 1983.

The American Occupational Therapy Association fully supports the Subcommittee's efforts to develop effective and efficient legislation regarding the education of health care personnel. The Association understands the importance of this legislation, not just for health practitioners but also for the people in need of their services. The well-being of the total health care system depends largely on the scope of the Federal government's committment to the education of health care personnel. The Association urges that, in defining the scope and degree of this committment, Congress give careful consideration to the integral and substantive roles played by the "allied health" professions and that accordingly it provide adequate support for their educational systems.

The American Occupational Therapy Association sincerely appreciates the opportunity to offer these comments.

AMERICAN ASSOCIATION OF DENTAL SCHOOLS
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March 31, 1980

Honorable Henry Waxman
Chairman, Subcommittee on Health
and the Environment
Committee on Interstate and Foreign Commerce
U.S. House of Representatives
Washington, D.C. 20015

Dear Mr. Chairman:

The American Association of Dental Schools would like to submit a statement for the record relevant to the various proposals for health manpower legislation pending before the House Subcommittee on Health and the Environment. In presenting our views on health manpower, we believe it is appropriate to outline first some of the most pressing problems facing dental schools and their students and then present our views about the appropriate Federal role in addressing these problems in conjunction with stated national priorities.

The most serious difficulty that the dental schools and their students must confront is that of finding ways to cope with the rapid escalation in the cost of providing and obtaining a dental education. For the dental school, the cost of educating a dental student reached a staggering figure of over $21,000 per year in the 1977-78 academic year and this represents an increase of nearly 60 percent within the most recent five year period of the average cost to the school of educating a dental student. This yearly educational cost to the institution is certainly one of the highest of the health professions. During the same five-year period, the amount paid by the average dental student for tuition and fees alone more than doubled, and by 1978-79, the average expenditure required to complete four years of dental school exclusive of living expenses had reached almost $20,000 for resident students and almost $25,000 for non-residents. For the average student attending a private institution, four-year school costs in that year exceeded $31,000. It is obvious that the increasing inflation will worsen a serious situation for both the institution and the student.

However, it is important to note that there have been several significant developments within the dental schools that have also contributed to institutional expense. Schools have expended large sums of money in order to comply with Federal requirements that are currently prerequisite for institutional support. In addition, effective and long overdue improvements in faculty-student ratios have been achieved. Technical equipment which rapidly becomes outmoded in highly used dental school clinics have needed replacement and clinical facilities have required renovation and modification in order to respond adequately to new program needs.

The primary concern of the dental schools is to maintain quality of their programs and remain financially viable. In a survey completed earlier this year by the American Association of Dental Schools, the schools that are receiving capitation grants were asked to specify the actions they expected to take in order to accommodate the reduced level of capitation funding in fiscal year 1979. Without Federal support dental schools in general would have to obtain replacement funds to support up to 57 percent of faculty and staff salaries. Private dental schools would have to obtain sufficient replacement funds for almost 62 percent of their faculty and staff salaries. One school anticipated the closing of the school library. All were concerned that the actions they were taking were making it increasingly difficult to recruit and to retain competent clinical faculty in the years ahead.

In addition, almost three fifths of the schools responding to the survey planned an immediate increase in tuition and fees to compensate in part for the reduction in FY 1979 funds. Some institutions reported that they would be forced to curtail or eliminate various student programs, including programs aimed at the recruitment and retention of minority students. Increases in tuition, no matter how necessary, would certainly exacerbate the serious financial problems that already confront the student who wishes to attend dental school. Current student assistance programs, although potentially workable, are both underfunded and are accompanied by heavily restrictive regulations which tend to eliminate many students particularly from the middle income group.

The Health Educational Assistance Loan (HEAL) program that was designed to assist students in these circumstances is not available at all to students in schools that have opted to forego capitation or to students in other schools who already borrowed in the same year under other Federal loan programs. Those students who are able to avail themselves of the HEAL program find that their original indebtedness is greatly inflated by the comparatively high interest rate provisions. To this educational indebtedness, the newly graduated dentists who wish to enter practice upon completion of their dental education must immediately incur large additional debts to establish their practices. Repayment of educational and practice indebtedness begins during a period in their careers when their earnings are their lowest.

What then is the Federal role in helping schools and students to address these serious difficulties? We believe this role is two-fold: (1) the Federal Government should supplement other sources of school income thereby assuring the fiscal stability of the schools so they can provide quality education for the future dentists of the country; and (2) the Federal Government should provide well designed and adequately funded student assistance programs, so that all students may be assured equal access to a dental education, and keep student indebtedness at a manageable level. We believe it is appropriate that the Federal Government assume these responsibilities because dental schools have demonstrated exceptional responsiveness in meeting national health manpower needs. Indeed, there are seventeen states without dental schools and these states must rely upon the schools located in other states for their supply of dentists.

Without a federal supplement it will be difficult and in some cases impossible for schools to generate sufficient income to attain anything resembling fiscal stability. It appears unlikely that income from private and state sources can adequately replace loss of revenues that would be experienced by a cut or elimination of institutional support from the Federal Government. We believe that it is essential for the Federal Government to assist the schools through institutional support to minimize their need for tuition increases.

Also, it is important for student assistance programs to be responsive to student needs rather than having the total cost of education the responsibility of the student because of the potentially high income of the health professions student after graduation.

Institutional Support

The Association endorses the continuation of institutional support for health professions schools as an important resource in maintaining fiscal stability for these institutions. We therefore applaud the philosophy in S. 2375 sponsored by Senator Edward M. Kennedy and H.R. 6802 sponsored by you, Mr. Chairman, of maintaining a viable realistic institutional support program. However, we are concerned that, with the exception of certain modifications, H.R. 6802 esentially provides a three-year extension for current institutional support authority. We believe that the assurances that dental schools must meet in order to receive capitation funds under the current authority are either obsolete or unnecessarily burdensome. Therefore, an extension of an institutional support program with these same requirements would be undesirable.

In our judgment, some of the principles contained in the national priority incentive grant package of S. 2375 will help dental schools maintain fiscal stability. However, a number of the incentives outlined in Section 772(e)(2) of that bill are unrealistic for the dental schools.

The incentive provisions in Section 772(e)(2) of S. 2375 would prove very difficult for dental schools to meet. The (a) and (b) provisions would be particularly difficult because the national applicant pool does not have 15 percent minority students from underserved minority groups or 40 percent women. Without qualified applicants, the schools could not possibly meet those incentives. In addition, the provision that 90 percent of graduates be in general practice will be difficult for schools to assure because the practice of pedodontics and public require advanced education that occurs after dental school and the dental schools have little or no contact with students after graduation. The provision of C(2) is troublesome because very few dental schools have residencies in public health or general practice. The training in these residencies takes place for the most part in hospitals and other institutions not affiliated with dental schools. In part (d) we suggest that the incentive be related to states without dental schools rather than health manpower shortage areas. This would be particularly relevant to the problem of health manpower distribution because, as we mentioned above, 17 states do not have dental schools. The off-site training provision for dental schools is very costly and could cost up to three to four times more per student than the institution would receive from the basic support. We therefore suggest that this provision of part (d) be optional. The Association fully endorses part (e) of S. 2375 and believes that it is a realistic component to meet stated health goals.

In addition, we suggest that other incentive options be made available which would further the ability of the schools to address national priorities. Section 731(c)(3)(B) of S. 2144 introduced by Senator Richard Schweiker provides that "the school conducts, or plans to conduct within twelve months, a community dental education and screening program designed to either (i) educate and screen the general population for controllable dental diseases or conditions or (ii) meet the dental education needs of a defined special population such as the handicapped, elderly, indigent or institutionalized children." Section 731(c)(4)(B) of that bill states "the school provides or coordinates within an existing system to provide or plans to do so within twelve months, a program for the delivery of primary or preventive dental care services to an underserved population, such as local prisoners or public health nursing home residents." Both 731(c)(4)(B and 731 (c)(3)(B) of Senator Schweiker's bill are direct service oriented and in our judgment provide schools with the opportunities to address the dental health care needs of targeted populations within the community. We recommend that such provisions be included in the list of options available to dental schools as assurances for institutional support.

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We emphasize that these assurances must be within the context of institutional support. We do not think that these objectives can be realized through project grant authorities because special project grants are targeted authorities carrying a forward commitment for operating resources and do not provide basic consistent financial assistance to the dental schools.

Student Assistance

The American Association of Dental Schools believes that the thrust of H.R. 6802 in incrementally improving the features of a working system of student assistance to health professions students is a sound approach to the complexities of student financial assistance problems. While we believe that the improvements suggested in H.R. 6802 are well conceived, we suggest that the additional modifications recommended by Senator Schweiker in his bill S. 1642 more adequately address the problem. S. 1642 would build on existing loan and scholarship programs by including provisions for interest subsidies for Health Education Assistance Loan (HEAL) recipients, elimination of the prohibition on HEAL recipients from receiving other government loans, extended repayment period for Health Professions Student Loans (HPSL) and continue the Exceptional Financial Need (EFN) Scholarship program. In addition, this bill, like H.R. 6802, S. 2375 and S. 2144, would effect a much needed graduated repayment provision. Such a provision would allow young practitioners to repay their indebtedness in keeping with the growth of their practices.

The Association believes that an expanded loan repayment program is more appropriate than the proposed service commitment loan program of S. 2375. A loan repayment program, if adequately funded, is much more effective in meeting the needs of shortage areas than are other need targeted programs. In our opinion, graduates who avail themselves of loan repayment would more likely remain in an area that needs dentists than an individual who made a commitment to serve in a need area as a precondition to receipt of a loan or scholarship early in his or her dental education.

Finally, the Exceptional Financial Need Scholarship program should be retained but amended. That program has been an important resource for dental students who otherwise would be unable to obtain a dental education. Unfortunately, appropriations for this program have been low and only one or two scholarships have been available to each dental school. We urge that the authority for this program be continued but amended to provide scholarship support for more than one year for the student who has an exceptional financial need and that adequate appropriations are provided each year.

Special Projects

The Association supports the proposal to continue some existing project grant authorities including General Practice of Dentistry Residencies, AHECs, expanded function dental auxiliaries, TEAM, interdisciplinary training, educational assistance to individuals from disadvantaged backgrounds and curriculum development. In particular, we believe that federal support should continue to be directed to General Practice Residency programs in dental schools and in accredited programs in hospitals and other appropriate entities. If the current authority for General Practice Residency programs is extended under the general section of Family Medicine Training and General Practice Dentistry Training as proposed in H.R. 6802, we strongly recommend the retention of the ten percent earmarking of funds in this section for the General Practice Dentistry Residency programs.

In addition, we support the proposed new grant authorities in S. 2144 for professional support mechanisms for dentists practicing in medically underserved areas, curriculum development in health care economics, continuing education projects and projects to demonstrate means of reducing the costs of health professions education and curriculum development.

The Association strongly supports Section 791 of S. 2375 providing special project funding to (1) develop new admission policies, procedures, and criteria for increasing enrollment of students who are committed to serve underserved populations, who are residents of

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underserved areas, or who are likely to enter general practice; (2) plan, develop, and operate, or maintain clinical education programs including preceptorships and interdisciplinary training in underserved areas or in health manpower shortage areas; or (3) plan, develop, and operate or maintain programs to provide individuals who meet or plan to meet the needs of underserved populations, education including continuing education and training related to the delivery of health care to medically underserved populations. All of these functions are of great importance and these project grant authorities would significantly further the current efforts of the dental schools in these directions.

The Association also believes that Section 793 of S. 2375 providing for grants for preventive medicine or dentistry training is particularly well conceived.

We endorse Section 795 of Senator Kennedy's bill dealing with special project grants in nutrition, geriatrics, rehabilitation and the containment of health care costs; as well as Section 796 providing funds to schools to increase the participation of women in health careers; and Section 797 providing for research and demonstration projects. All of these functions are in the best interest of the dental schools that have the resources to develop such programs and of the nation at large.

Construction Grants

While the Association supports the provision in H.R. 6802 repealing the requirement imposed on previous grantees for increased enrollment as a condition for receiving construction grants, we do not believe that total elimination of construction grant authority is advisable. Funds should be provided under the construction grant authority to replace equipment and renovate outmoded teaching facilities. Although most dental schools have been built, replaced, or renovated within the past fifteen years, many need to replace equipment and to modernize educational facilities to keep pace with changing technology. Unlike medical schools which ordinarily have access to hospitals and clinical equipment, dental schools are largely self-contained and must provide their own high cost equipment. Because this equipment is utilized daily it becomes worn and needs to be replaced in a short period of time.

Financial Distress

In our judgment, financial distress authority should adequately reflect the magnitude of need that could result if institutions face unexpected financial problems. We therefore support extension of existing authority for financial distress grants with the further recommendation that authorization levels be high enough to anticipate adequately the potential increases in the number of dental schools that might experience financial distress in the near future.

National Health Service Scholarships

The Association supports the basic concept of S. 2144 in phasing down the National Health Service Corps scholarship program to a level that is consistent with realistic shortage area requirements. We believe that a program primarily administered at the state level would likely be more responsive to the real problems of meeting the needs of underserved populations. The Association thinks that continued phased-down support for National Health Service Corps Scholarship authority is appropriate, but should be retained until a shift of such responsibility can be assumed by the states. Continuation of the NHSC scholarship provisions should not be considered a general student assistance provision and must be coordinated to the needs for career NHSC dentists in state designated shortage areas. We are particularly concerned about recent trends to expand the National Health Service Corps scholarship program at the expense of other student assistance such as the Health Professions Student Loan program, and Exceptional Financial Need Scholarship program. We do not support the concept that the NHSC is the principle source to effect a better distribution of health manpower. Programs such as the National Health Professions Placement Network are realistic methods to match community need and health manpower availability. NHSC should be the resource available to need areas that have no other way to alleviate shortage of health manpower. In short, we believe that NHSC scholarships should be limited to those dental students that intend to serve in the National Health Service Corps as a career and the number supported should not exceed the number expected to be needed in the year of graduation and available for service.

In the past, the total number of NHSC scholarships available to dental students has been relatively small compared to total enrollments in the dental schools and the total number of scholarship recipients. The Kennedy bill proposes to earmark 80 percent of NHSC scholarship appropriations for schools of medicine and osteopathy. To assure that needed scholarships are available for dental students, we suggest that earmarked funds for those students be continued as proposed by H.R. 6802.

Mr. Chairman, we appreciate the opportunity to make these comments. If the American Association of Dental Schools can provide any assistance to you, the members of the Subcommittee or the staff, please do not hestitate to contact us.

Sincerely,

Harry W. Bruce Jr.

Harry W. Bruce, Jr., D.D.S.
Executive Director

HWB/jf
cc: Mr. Hal Christensen
Dr. Thomas J. Ginley
AADS Executive Committee

Coalition of Independent Health Professions

Office of the Legislative Chair

6000 Executive Boulevard
Rockville, Maryland 20852

April 4, 1980

The Honorable Henry A. Waxman, Chairman
Subcommittee on Health & The Environment
Committee on Interstate and Foreign Commerce
2424 Rayburn House Office Building
Washington, D. C. 20515

Dear Mr. Chairman:

On behalf of the Coalition of Independent Health Professions (CIHP), I am pleased to have this opportunity to submit to you for the record the following statement of CIHP concerns and recommendations with respect to the present proposed legislation to amend and extend the current health and manpower training authorities contained in Title VII of the Public Health Service Act, as amended, the subject of hearings held before your Subcommittee on March 25, 1980.

CIHP was formed in the spring of 1970 as a vehicle for shared leadership in health care matters and provides its member organizations a forum for receiving and sharing information on health planning and the delivery of health care services. Membership in the Coalition is accorded to organizations which are broadly representative of discipline-centered professions with significant involvement in the delivery of health services and, collectively, CIHP represents over a quarter million non-physician health care professionals. Membership in CIHP is composed of the following organizations:

American Association for Clinical Chemistry
American Association of Bioanalysts
American Association of Pastoral Counselors
American Dietetic Association
American Occupational Therapy Association
American Optometric Association
American Physical Therapy Association
American Society for Medical Technology
American Speech Hearing and Language Association
National Association of Social Workers
National Rehabilitation Counseling Association

MEMBER ORGANIZATIONS

American Association of Bioanalysts
American Association of Pastoral Counselors
American Dietetic Association
American Occupational Therapy Association
American Optometric Association
American Physical Therapy Association
American Society for Medical Technology
American Speech and Hearing Association
National Association of Social Workers
National Rehabilitation Counseling Association

Insofar as allied health professionals comprise approximately three-fifths of the total health work force which now numbers over 5 million, and insofar as CIHP represents a significant portion of these allied health professionals, we are intimately concerned with the management of and the direction to be taken by America's health care delivery system.

Definition of Allied Health

CIHP is particularly concerned with the current inadequate and inappropriate definition of "Allied Health Personnel" as set forth in Section 795(1) and continued in Section 795(2) of the current statute. CIHP perceives this current definition as both inappropriate and derogatory, and this to the extent that at least one component organization of CIHP has for some time strongly dissuaded its members from seeking federal training assistance under the Part G Allied Health Authorities of Title VII.

This current system which, in effect, requires health care professionals to derogate their professional status as a condition for the award of federal assistance does not further the legislative intent on which the Part G authorities were based, nor does it contribute to the solution of the needs and shortages these authorities were meant to address.

The examples of allied health personnel in Section 795(2) are, in the first instance, not truly representative of the spectrum of non-physician health care providers, nor, in the second instance, are definitions even necessary in light of the fact that none are offered for medical, dental, or podiatric personnel.

The preferable standard to be applied is that which is currently applied to these latter professions, i.e., definition of the schools which train these medical, dental, or podiatric personnel should be the model standard by which allied health personnel are determined. Consequently, we suggest that the Subcommittee amend H.R. 6802 to:

> delete section 795(1) of the current statute and amend the current section 795(2) by substituting, in lieu thereof, the following legislative language.
>
> > The terms "training center for allied health personnel" and "school of allied health" mean a public or nonprofit private junior college, college, or university --
> >
> > (A) which provides, or can provide, programs of education in a field of allied health leading to a baccalaureate or associate degree (or an equivalent degree of either) or to a more advanced degree;
> >
> > (B) which provides training for not less than a total of twenty persons in such curricula;
> >
> > (C) which, if in a college or university which does not include a teaching hospital or in a junior college, is affiliated with such a hospital; and
>
> Subsection (D) of existing section 795(2) should be retained.

Data Studies

CIHP strongly feels that an additional emphasis should be placed on data studies in allied health. A recent study, entitled A Report on Allied Health Personnel, prepared by the Bureau of Health Manpower of the Health Resources Administration pursuant to section 702(d) of the Health Professions Educational Assistance Act of 1976 (P.L. 94-484), as amended, has, among its many findings stated:

> "There are insufficient data about allied health personnel at the local, state, or national level to permit radical improvements in planning, production, and management. The large number of occupations and functions involved, and their interrelations, makes good planning for allied health personnel difficult. Improved data on production, recruitment, reimbursement, utilization, service costs, and work force quality are needed. Data on improvements in supply, work force quality, educational standards and methods, and opportunities for minorities are difficult and costly to produce and generally less than satisfactory. Where improvements have occurred, federal support appears to be a decisive factor."

Another report has been completed as the end product of a two-year study conducted by the National Commission on Allied Health Education. This report, entitled The Future of Allied Health: Alliances for the 1980's, arrives at much the same conclusion as the above cited Report:

> "The Federal government should support the systematic and continuous collection and dissemination of data on the numbers and distributions of health manpower in all occupational areas, including information on projected openings. Support also should be made available for the continuation of biennial national inventories of allied health programs, expanded to include all settings which continue to offer formal post-secondary education programs."

Currently, the federal government supports allied health related data collection relating only to those allied health schools defined in existing section 795(2), those awarding the associate, baccalaureate or higher degree, and does not take into account the increasing number of allied health institutions which award certificates as opposed to degrees. Consequently, and to accomplish these aims, we urge the Subcommittee to:

> amend the existing data collection language of section 708

or to:

> add a new section to Part G to accommodate the need for the collection of allied health (including post-secondary nonprofit and proprietary institutions which grant practice "certificates" in allied health disciplines, including data relating to production, recruitment, reimbursement, utilization, service costs, work force quality, educational standards and methods, and opportunities for minorities.

Access to Grants

The Report of the Bureau of Health Manpower concludes that:

- While some of the previous shortages of allied health personnel have been alleviated or eliminated, there remain significant shortages in the areas of respiratory therapy, speech pathology, and audiology, and that, to a lesser degree, shortages remain of formally trained dental assistants, in dietetics, radiation therapy, occupational therapy, and physical therapy;
- The duties and responsibilities of allied health personnel have markedly increased in recent years;
- As a cost-saving strategy, increased use of allied health personnel is thought to have considerable potential, especially in HMO's and long-term care; and
- The quality of training has increased significantly in recent years, but further improvements are required.

Consider also the statistics from the Occupational Projections and Training Data, Bureau of Labor Statistics, with an expected publication date of May 1980. Reproduced here for the Subcommittee's convenience are the statistics for a number of the allied health professions:

Occupation	Estimated employment 1978	Projected employment 1990	% Of Change
Optometrists	21,000	26,000	25.2
Medical laboratory workers	210,000	265,000	26.2
Occupational therapists	15,000	30,000	100.0
Occupational therapy assistants	10,000	15,000	50.0
Physical therapists	30,000	45,000	50.0
Physical therapy assistants and aides	12,500	15,000	20.0
Dietitians	35,000	50,000	42.9
Rehabilitation counselors	19,000	NA*	NA*
Social workers	385,000	475,000	24.2
Speech pathologists and audiologists	32,000	60,000	87.5

*NA - data not available

CIHP therefore urges the Subcommittee to reconsider this pattern of allocation, and suggests the following legislative action:

> the purposes of section 798 should be retained in the Subcommittee's final legislative proposal. In addition, the following project support emphases should be added to those already enumerated: projects which focus on allied health role delineations and related interdisciplinary curriculum modules; on meeting new health-service needs without creating new specialities; on the development of mechanisms for interdisciplinary articulation; on the use of allied health practitioners in containing health care costs; on the allied health related needs of unserved and underserved areas; and on curriculum offerings in health promotion, disease prevention, geriatrics, and health planning. The authorization levels for existing section 796 should be $30 million for fiscal 1981, $32 million for fiscal 1982, $34 million for fiscal 1983, and $36 million for fiscal 1984.

Existing section 797 authorizes $5.5 million for the current fiscal year for institutes generally designed to accommodate the "advanced" learning needs of allied health practitioners who, principally as a result of the rapid expansion of the allied health fields and increases in the numbers and varieties of allied health opportunities and initiatives, find themselves in new educational, supervisory, or administrative settings. CIHP urges that this emphasis be continued and, therefore, recommends that the final Subcommittee proposal:

> include existing section 797 through fiscal year 1984 at annual authorization levels which are equal to that of the current fiscal year.

A significant aspect of the Congress' rationale for initiating, in 1966, federal support programs in allied health education was its belief that the allied health professions could help the health care delivery systems need to increase services to unserved and underserved areas of the country. Allied health has since proven its effectiveness in these areas -- allied health services are diverse; so are the critical health care needs in unserved rural and urban areas. Yet the allied health professions have been virtually ignored by National Health Services Corps planners.

In 1979, for example, only 28 of 2,379 NHSC scholarships went to allied health students (all 28 were awarded to master's level students in public health nutrition programs). It is difficult to believe that podiatry services, for example, are any more crucial to the health care needs of underserved populations than the services of audiologists or physical therapists or rehabilitation counselors (106 podiatry students benefited from NHSC assistance in 1979). Consequently, CIHP urges the Subcommittee to:

> include students in the allied health professions among the health professions students qualified for NHSC education assistance and service.

Moreover, we hope the Subcommittee's report will recognize that:

> clinical training, health policy and health care economics, continuing education, educational costs, curriculum development, and the role of women in health care education and service are all appropriate areas for special federal funding emphasis. Allied health training programs should be specified as appropriate recipients of such special funding.

With regard to the above documented evidence of national shortages in the manpower forces of the allied health professions, CIHP specifically urges the Subcommittee to report an amendment to existing section 796 to:

> enable the Bureau of Health Manpower to provide special incentive support to allied health education programs which train students in disciplines identified as "significant national shortage" areas, notably audiology, speech pathology, respiratory therpay, dietetics, dietetic technology, physical therapy, occupational therapy, radiation therapy, and dental assisting.

CIHP sincerely appreciates this opportunity to present its concerns for the record of these hearings. We are also pleased to offer you or your Subcommittee staff the assistance of our personnel should any additional information or assistance be required.

Sincerely,

R. Charles Harker

R. Charles Harker
Legislative Chair, CIHP

JOHN P. PERRIN, DIRECTOR

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American Osteopathic Association

April 11, 1980

The Honorable Henry Waxman
Chairman, Subcommittee on Health
House Committee on Interstate and
  Foreign Commerce
U.S. Capitol
Washington, D.C. 20515

Dear Mr. Chairman:

The American Osteopathic Association supports the focus and major provisions of H.R. 6802, the Health Professions Education Assistance and Nurse Training Amendments of 1980. The programs proposed in the legislation will serve to assure that national health care goals are met, while acknowledging the budgetary constraints that inflation necessitates.

The AOA has concurred in testimony presented before your Subcommittee by the American Association of Colleges of Osteopathic Medicine. We would now like to take this opportunity to comment on some specific provisions of H.R. 6802 which are of particular concern to the osteopathic profession.

We support your proposals to extend National Health Service Corps programs and to encourage utilization of private practice pay back options for NHSC scholarships. Students of osteopathic medicine have made significant use of the NHSC programs, helping to meet the needs of America's medically underserved populations; as you may know, more than 40% of all osteopathic physicians ultimately practice in physician shortage areas.

The AOA also applauds your commitment, outlined in Part B of Title II of H.R. 6802, to continue health professions student loan assistance. Although we are in favor of the program, outlined in Section 205(b), to provide deferrals on interest payments of Federally insured student loans, the three year deferrals provided for in this subsection would not cover some osteopathic students, because of the AOA's requirement that students participate in a one-year rotating internship prior to any residency training. Accordingly, we recommend that the allowable period for deferrals of interest payments be extended to four years.

The Institutional Support Grants provided for in Part C of Title II are strongly supported by the AOA. These "core" support grants will help insure that health professions schools will continue to be able to develop and implement responses to national health priorities. The importance of retaining core institutional support cannot be overstated, and we greatly appreciate your acknowledgment of this need.

Part D of Title II reauthorizes the Special Project Grants currently provided for in Sections 780, 784 and 786 of P.L. 94-484. The AOA supported institution of these programs originally, and is pleased to note your dedication to their continuation. The original language of Section 780, however, poses a problem for the osteopathic profession, as it is predicated on the structure of the allopathic postdoctoral training model. Specifically, Section 780 mandates that grant eligible entities must have "control" over a three year approved or provisionally approved residency training program in family practice. Virtually all osteopathic residency training programs are conducted in satellite, community teaching hospitals which are affiliated with, rather than controlled by, schools of osteopathic medicine. We believe the intent of Section 780 (b)(1)(D) of P.L. 94-484 was to assure that students trained in programs receiving federal funds would have residency training slots available to them. Amending Section 215 of H.R. 6802 to alter the language of Section 780 of P.L. 94-484 to require that grant eligible entities maintain "affiliation agreements" with hospitals operating family practice residency training programs will serve to promote continuity in training, while insuring that osteopathic institutions will be eligible for family practice funding.

Section 230 (f) of Part E, Title II amends P.L. 94-484 to authorize grants to health professions schools to establish administrative units in preventive medicine and to improve predoctoral and postdoctoral instruction in preventive, community, or occupational medicine. Again, due to the uniqueness of the osteopathic postdoctoral training model, teaching hospitals must be included among the grant eligible entities if improvements in osteopathic postdoctoral training programs are to be accomplished. Further, this section amends P.L. 94-484 to provide grants to schools of medicine and public health to "plan and develop new residency training programs and to develop and expand accredited residency training programs in preventive medicine." The AOA requests that you amend this section to include schools of osteopathic medicine and osteopathic teaching hospitals among the entities eligible for these grants.

The AOA supports the provisions outlined in Titles III, IV and V of H.R. 6802. The changes in reimbursement policy proposed in Sections 501 and 502 will provide further inducement for hospitals to increase their number of primary care residency positions, thereby meeting a national goal.

The AOA appreciates the opportunity to comment on the foregoing specific problems of H.R. 6802. We stand ready to work with you and your staff and to provide any additional information you may require. Thank you again for your continued support of health professions education generally, and your sensitivity to the needs and contributions of the osteopathic profession.

Sincerely,

John P. Perrin
Director

JPP/tgr

[Whereupon, the subcommittee was adjourned at 11:40 a.m.]